The Modern Hospital

JULY 1956

NEW UNIVERSITY OF MISSISSIPPI HOSPITAL, JACKSON, MISS. (PAGE 57)

OVER AND OVER AND OVER AND OVER

hospitals re-ordered HAUSTED

EMERGENCY AND RECOVERY ROOM STRETCHERS

Many factors effect a sale — personality, friendship, a convincing manner, a good "pitch".

But there is **only one factor** in a re-order — COMPLETE PRODUCT SATISFACTION!

When hospitals re-order HAUSTED stretchers it means they want HAUSTED stretchers over all others, it means HAUSTED stretchers HAVE SOLD THEMSELVES—IN USE—HAVE GIVEN COMPLETE PRODUCT SATISFACTION.

Listed below are some of the hospitals that have re-ordered HAUSTED stretchers FOUR TIMES! Hundreds of others have re-ordered twice, three times, even five and six times!

Ohio State University Hosp.
Columbus, Ohio

St. Joseph's
Denver, Colorado

Halifax District
Daytona Beach, Florida

Homer G. Phillips
St. Louis, Missouri

University Hospital
Cleveland, Ohio

Cabarrus Memorial
Concord, North Carolina

Good Samaritan
Phoenix, Arizona

Kings County Hospital
Brooklyn, New York

Veterans Administration
Dayton, Ohio

Hinsdale San. and Hosp.
Hinsdale, Illinois

St. Mary's Mercy
Gary, Indiana

Lima Memorial
Lima, Ohio

Veterans Administration
Togus, Maine

Medical College
Charleston, S. C.

Marymount
Garfield Heights, Ohio

Baroness Erlanger
Chattanooga, Tenn.

Lewistown Hospital
Lewistown, Pa.

Mayview State
Mayview, Pa.

Middletown Hospital
Middletown, Ohio

McKeesport Hospital
McKeesport, Pa.

Mount Carmel
Columbus, Ohio

Mary Immaculate
Newport News, Virginia

Tampa Municipal
Tampa, Florida

Union Hospital
Fall River, Mass.

the HAUSTED *Manufacturing Co.*

SEE OUR COMPLETE DISPLAY AT YOUR REGIONAL CONVENTION MEDINA, OHIO

The Modern Hospital

JULY 1956

VOLUME 87, NO. 1

ADMINISTRATION

VOLUNTEER FORUM

MEDICINE AND PHARMACY

FOOD SERVICE

MAINTENANCE AND OPERATION

HOUSEKEEPING

REGULAR FEATURES

Lilly

Therapeutic Briefs

SELECTED PRODUCTS USEFUL IN ALLERGIC CONDITIONS

FAST, PROLONGED RELIEF FROM ALLERGY

CO-PYRONIL

(Pyrrobutamine Compound, Lilly)

. . . usually eliminates distressing symptoms without causing side-effects; allows those affected with allergy to enjoy summertime. 'Co-Pyronil' produces complete relief more frequently because of the complementary actions of two antihistaminics and a sympathomimetic.

Supplied as pulvules, pediatric pulvules, and suspension. Also, Tablets 'Pyronil' (Pyrrobutamine, Lilly), 15 mg.

FOR SUNBURN, HEAT RASH, POISON IVY, INSECT BITES

SURFADIL

(Cyclomethycaine and Thenylpyramine, Lilly)

. . . controls itching and pain, speeds healing. The lotion also shields the skin from the sun's rays and is skin tone in color. Lotion 'Surfadil' is supplied in convenient, unbreakable plastic squeeze bottles of 75 cc.; also available in pint bottles. Cream 'Surfadil' is supplied in 1-oz. tubes and 1 and 5-lb. jars.

RAPID RELIEF FROM ASTHMATIC ATTACK

AEROLONE COMPOUND

(Cyclopentamine and Aludrine Compound, Lilly)

. . . achieves unusual effectiveness by taking advantage of the additive dilating action of four potent bronchodilators. Acts instantly to relieve "air hunger." Side-effects are minimal.

Supplied in 1-oz. bottles. Administered by means of a nebulizer.

PREVENTS ASTHMATIC ATTACKS

AMESEC

. . . combines sympathomimetic action with bronchorelaxing effect and sedation. Amesec counteracts the accumulation of mucus, relaxes smooth-muscle spasm, and reduces nervous unrest incident to attacks.

Supplied as pulvules and 'Enseals' (Timed Disintegrating Tablets, Lilly), in bottles of 100 and 500.

80TH ANNIVERSARY 1876 · 1956 / ELI LILLY AND COMPANY

AMONG THE AUTHORS

Eleanor F. Christian, author of the article on mental hospital records, is assigned to the 4167th U.S. Air Force Hospital at Travis, Calif. Mrs. Christian was formerly medical record librarian at Atascadero State Hospital, Atascadero, Calif., a "maximum security" hospital of 1084 beds. Mrs. Christian was a medical record librarian at several general hospitals before she entered the state hospital service in California several years ago. "Both the hospital and its program are different from the usual mental hospital," she said of Atascadero Hospital, "and offer a challenge to the medical record department."


Helen Cassidy

Helen Cassidy is purchasing dietitian at St. Luke's Hospital, New York City. She received her B.S. degree in home economics from Marywood College, Scranton, Pa., and served her dietetic internship at St. Luke's. Miss Cassidy has been associated with the hospital since 1951, when she started teaching nutrition and diet therapy to student nurses. Before taking on her present assignment, she was in charge of the nurses' residence cafeteria. Her article on food purchasing and control appears on page 116.

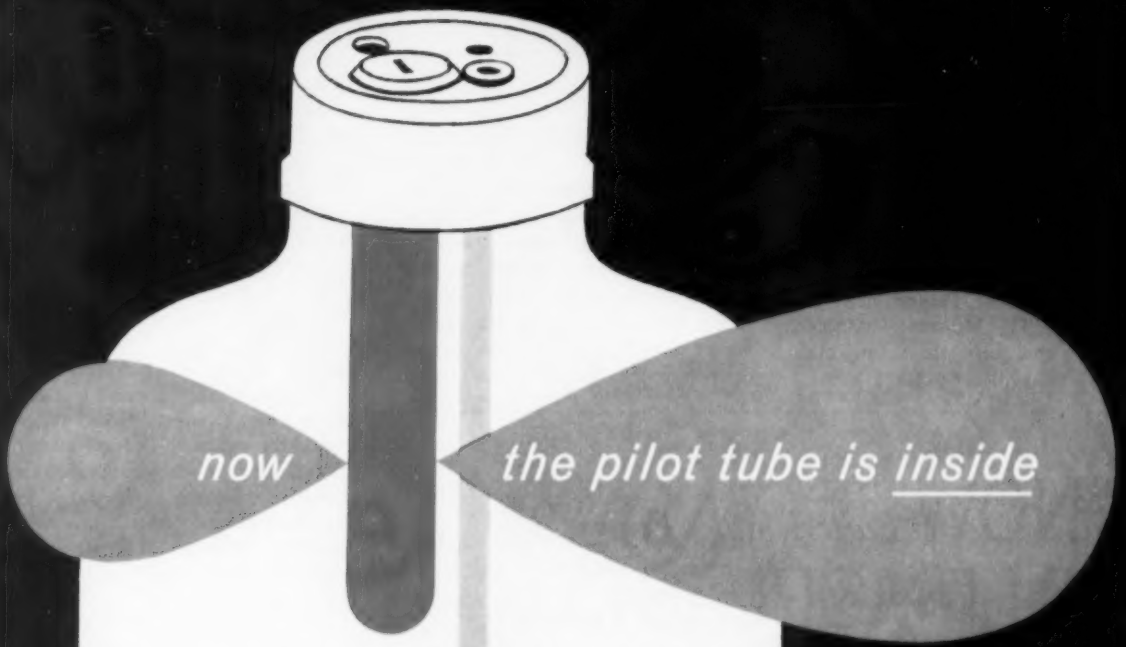

James W. Cooke

James W. Cooke is administrative assistant at the Akron City Hospital, Akron, Ohio, where he developed the central equipment room described in the article on page 79 as a part of the hospital's central supply department. Mr. Cooke is a graduate of Michigan State University, with degrees in hotel management and institutional administration. He received the master's degree in hospital administration from Northwestern University in June 1954 and served his administrative residency at Lakewood Hospital, Lakewood, Ohio.


Kenneth P. Cohen

Kenneth P. Cohen is administrative assistant at the Jewish Hospital, St. Louis, where his assignment is in management engineering. A graduate of Washington University, St. Louis, with a degree in industrial engineering, Mr. Cohen is presently enrolled in the extension course in hospital administration at St. Louis University. Before entering the hospital field, he did industrial engineering in the metal, plastic and textile industries. His article describing a methods engineering study of the new laundry installation at Jewish Hospital appears on page 126.

Other authors in this issue include **Dr. David B. Wilson,** director of the University Hospital, University of Mississippi Medical Center, Jackson; **Mrs. Elizabeth Kingsford,** assistant to the director, and **R. W. Naef,** architect, who collaborated in the presentation of this month's Hospital of the Month beginning on page 57. Mr. Naef, of the firm of E. L. Malvaney, R. W. Naef, and N. W. Overstreet, Jackson, Miss.; which designed the medical center, has recently been elevated to fellowship in the American Institute of Architects in recognition of his contribution to his community.



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only one label required

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prevents errors—SERA-VAC's internal pilot tube cannot be mislabeled, interchanged, lost or broken.

saves time—SERA-VAC eliminates labeling and taping of pilot tube to bottle...one less tube to handle.

stores easily— VAC packs tightly and rotates easily for daily inspection.

improves clot retraction—SERA-VAC's pilot tube is warmed by blood around it...pilot tube blood cools more slowly.

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AMERICAN HOSPITAL SUPPLY CORPORATION

SCIENTIFIC PRODUCTS DIVISION GENERAL OFFICES • EVANSTON, ILLINOIS

READER OPINION

Patient Care Elements

Sirs:

I have been very interested in making a comparison of our 115 bed hospital with the figures quoted on pages 72, 73 and 74 of Dr. Louis Block's article, "Analysis of Patient Care Elements," in The MODERN HOSPITAL for May, and there are a few comments I would like to make.

I believe it would be helpful to show the year or period covered by the statistics quoted. In our own case our figures increase about 10 per cent a year, so that if our comparison should be made with 1954 instead of 1955 there would be some difference.

We assume that under nursing the figures quoted include operating room, delivery room, and anesthetists, or do these cover just the nursing service concerned with patient care?

Are the figures for personnel based on the entire number of full-time employes on the payroll or are they the number of full-time employes required to give service on a given day?

It would also be interesting to know how many hospitals there were in each of the categories instead of just the total of 162 institutions.

What is the definition of an operative delivery? On the usual analysis form, which gives the comparative report of professional performance, no such data are called for and I presume are not usually kept. Would the statistics on neonatal deaths, maternal deaths, cesarean deliveries, and total operative deliveries be expressed in a rate per thousand rather than in actual numbers? This would again conform with the usual type of statistics kept on the analysis forms.

J. H. Zenger
Administrator

Utah Valley Hospital
Provo, Utah

Dr. Block Replies

Sirs:

With reference to Mr. Zenger's specific questions, I should like to refer to the original article which started in the March 1956 issue of The MODERN HOSPITAL, page 86. This article gave more detailed information regarding the 162 institutions studied, the year of the data analyzed, and other information pertinent to his request. I believe that when he indicates that his own figures increase about 10 per cent a year, he might have a more specific reference to hospital finances, rather than to services. In analyzing the Ohio state data, we realize that finances, probably more than any other area of service, would vary from year to year, and for that reason omitted them from the analysis.

With regard to Mr. Zenger's query regarding nursing personnel, he is quite correct in assuming that the figures quoted include nursing personnel throughout the hospital, including operating room, delivery room, and anesthetists. His further reference to the over-all employe figure does, in fact, relate to the entire or total number of full-time employes on the payroll.

The term "operative delivery" as used in this report refers to instrumentation delivery. It is a term used by the Ohio State Department of

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FAMOUS HARD
QUALITY AND SAFETY
INTO ANY BUDGET!

HARD Triple Service MULTI-HITE BED

AVAILABLE IN THREE STYLES

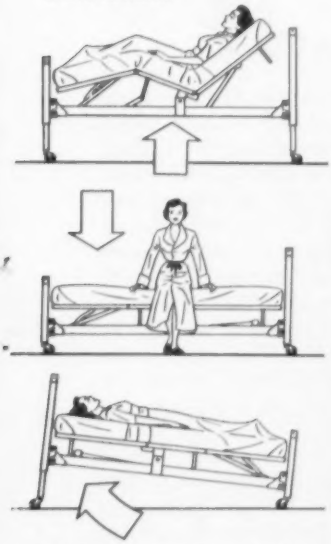
1. **SINGLE CRANK SERVICE**—raises and lowers spring with hand crank operation from four convenient positions.
2. **SINGLE CRANK SERVICE WITH NUR-SAVER***—Motor driven unit adjusts headrest automatically.
3. **ELECTRO-MATIC SERVICE***—Motor driven unit raises and lowers complete spring automatically. Saves nurses time and energy, bed adjusts to desired height while nurse performs other duties.

***CONVERT MULTI-HITE BEDS NOW IN USE** to automatic operation with Hard *Power Pack* (for *Electro-Matic Service*) and *Nur-Saver* units. Contact your dealer-salesman, or write

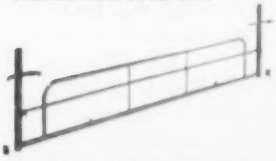
HARD MANUFACTURING COMPANY
Buffalo 7, New York

Shown below is Hard's 5 Feature Omega Room Group

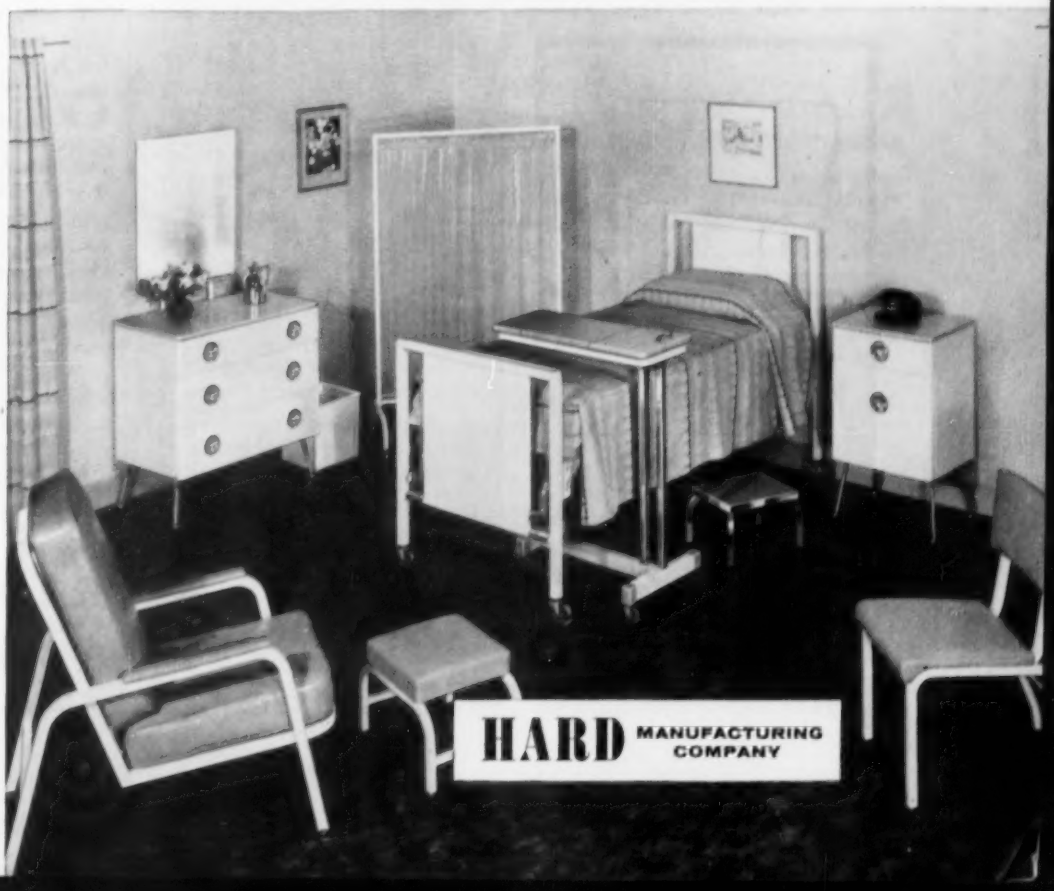
Chrome baffle plate protects finish, provides easy access to gears. Stainless steel scuff plate is also standard.



Offers more treatment positions more quickly than any other comparable bed on the market because it can be cranked from either end.



Available with Hard Slida-Side, the modern space-saving safety side. Fittings are standard on all Multi-Hites for easy installation of Slida-Sides.



Health in its request for information, and is understood by the Ohio hospitals. It is true that this terminology is not in common use, and that the reference to operative delivery as such can vary from actual surgical deliveries, such as cesarean sections, to the aforementioned instrumentation deliveries.

Mr. Zenger indicates the fact that such information as neonatal deaths, maternal deaths, cesarean deliveries, and other such information might better be presented as a rate, rather than as a number. I too believe that, for comparison purposes, he is probably correct. This fact shall be kept in mind in the development of such studies in the future.

Louis Block, Dr. P. H.

For Better Purchasing

Sirs:

After reading "Sharp Deals Cut Two Ways" by Edward Heyd in the May issue of The MODERN HOSPITAL, we, the executive committee of the Hospital Purchasing Agents Association of Texas, are pleased to congratulate you on the publication of an article which exemplifies the buyer-supplier relationship in many hospitals today.

In Texas, we have organized the HPAAT to combat the many examples of faulty or sharp practices that he cites. We held our first state meeting in conjunction with the Texas Hospital Association convention in April this year. To our knowledge, we are the first statewide hospital purchasing agents association in the nation. However, and in spite of our youth and untried status, three other states, Oklahoma, Kansas and Louisiana, have made inquiry to our organization and are considering setting up similar associations.

One of the objectives of our association is to correct trade abuses and to strive by all legitimate means to advance the hospital purchasing profession. Mr. Heyd states in his article that "if the purchasing agent has a basic, over-all philosophy to guide him —something equivalent to the profit motive in industry—it is undoubtedly to contribute to the best patient care possible with the available funds." To this end, we have taken as our motto, "Better Purchasing for Better Patient Care."

Guy E. Whale Jr.
Purchasing Agent
Methodist Hospital of Dallas, Tex.

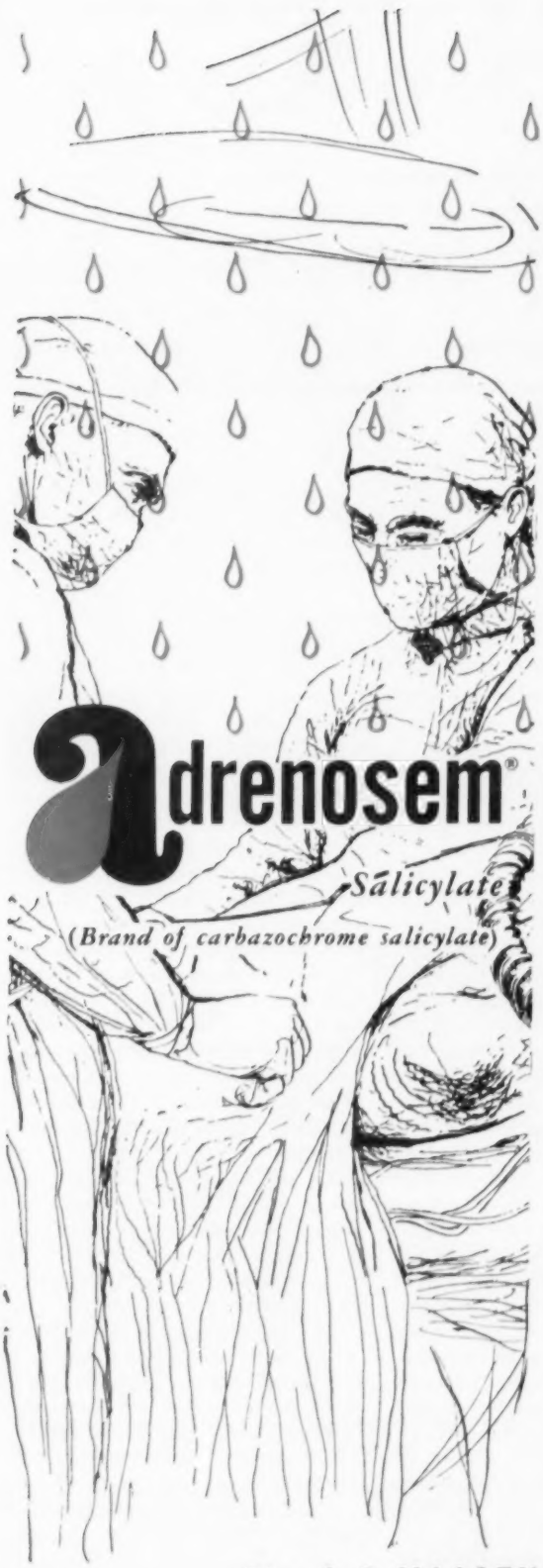
Food Service Is Good

Sirs:

I am a food administrator at the Chesapeake and Ohio Hospital in Clifton Forge, Va. employed by Hospital Dietetics, Inc. of Cleveland. The capacity of the hospital is 220 beds; we serve approximately 1300 meals per day, inincluding patients, staff and employes. Our kitchen staff consists of: food administrator, assistant food administrator, dietitian, assistant to dietitian, clerk, stock boy, first cook, second cook, pastry cook, and 16 kitchen employes to cover all jobs plus night work.

We have a staff dining room in which we also serve patients' visitors at certain hours. We have an employes' dining room for all employes. For patients we use the heated dish system. These data are of importance so you will understand why I am writing the following:

I have been in the hospital food service for five years, three of which I was chief dietitian at the Medical Center for Federal Prisoners, Springfield, Mo., for the federal Department of Justice. The other two years I have



"...specific for conditions characterized by increased capillary permeability."
1

Adrenosem® to control bleeding

Salicylate

(Brand of carbazochrome salicylate)

In his study of 330 hospital cases treated with Adrenosem* Salicylate, Bacala concludes that this systemic hemostat is "specific for the strengthening of capillary resistance."

He summarizes: "Experience with the drug is cited from 317 surgical and 13 obstetricogynecological cases. Most numerous were the 233 tonsillectomies, of which 207 patients were benefited by its use; post-tonsillectomy bleeding was reduced from 19.8 to seven per cent. The drug was also found useful in gastrointestinal bleeding, cataract extraction, epistaxis, incisional seepage, transurethral prostatectomy, menometrorrhagias, cervical oozing, antepartum and postpartum bleeding, threatened abortion, and prevention of capillary hemorrhages during Hedulin or Dicumerol therapy."[1]

1. *Bacala, J.C.: The Use of the Systemic Hemostat Carbazochrome Salicylate, West. J. Surg. 64:88 (1956).*

Supplied in ampuls, tablets and as a syrup.

Write for comprehensive illustrated brochure describing the action and uses of Adrenosem Salicylate.

**U.S. Patent 2,581,850*

The S. E. MASSENGILL company BRISTOL, TENNESSEE

NEW YORK KANSAS CITY SAN FRANCISCO

CHESAPEAKE & OHIO RAILWAY EMPLOYES HOSPITAL

Room _____ Date _____ Name _____

S	Soup		OR	Juice	Dinner Roll
U	Breaded Veal Cutlets		OR	Boiled Franks	White Rye Whole Wheat
P		Baked Beans			Butter
P	Asparagus		OR	Sauerkraut	Jelly Tea
E		Lettuce and Tomato w/french dressing			Coffee Milk
R	Fruit Jello		OR	Prune Plums	Cream Sugar
		Cocoa			Lemon

8:00 P.M. Nourishment _____ Milk or Fruit Juice

Sample of selective dinner menus offered to all patients.

been with C. & O. Hospital, in my present capacity.

It exasperates me to read articles on how disgraceful food service operations are in various hospitals. For once I would like people to read and know that, in the not too distant future, hospitals will be *the* place to eat. We have proved that at this hospital and are in the process of proving it at others. Naturally, I would like to use this institution as an example for I know that finer food, finer service and, most of all, finer kitchen employes could never be hoped for.

Sure we have our problems, but who doesn't? When a problem arises, I have four well trained people under me who are capable of adjusting any problem immediately. We have absenteeism, sickness and many other things that most institutions consider a problem. Here it is just unfortunate that it happens, but it is far from being a catastrophe; nor do we get ulcers over it. As for turnover, we have very little except for one job and that is a kitchen cleaner. Once again this is just something to take care of.

Another thing that is always brought up is salaries. Administrators are always saying that because of low hospital salaries employes are of the lowest type. I'll agree that in some cases salaries are low but not the employes. At this hospital salaries are in the low category, but in most cases we are paying higher wages than most hospitals in the state of Virginia. A lot of people forget to ask: What do you give your employes? Here they get three meals per day, uniforms, free medical and surgical care, and also railroad retirement plan. They receive two weeks' vacation with pay and two weeks' sick leave with pay.

We use the selective menu system here, which is undoubtedly the key to successful food operation. We have approximately 50 to 60 special diets of all types and each patient has the opportunity, because of frequent visits by the dietitian, to be fussy and ask for anything in the way of food he would like to have and his requests are met. Such requests, for example, might include shrimp cocktail, Cornish hens, strip steaks, or filet mignon. I should add that such items are prepared only upon request; they are not part of the general menu.

The patients, staff and employes have the opportunity to eat all they want; we have no limit. Everyone is given the proper portion at first and he can feel free to come back for seconds, thirds, or even fourths. A good many always come back for seconds. With selective menu the patients can choose what they want or choose all of the selections or ask for something in addition if they desire. Enclosed is a sample menu.

We use all portion control meats, portion control fish, individual sirup, jelly, jams, ketchup, salt and pepper and sugar. Our vegetables are all frozen, Grade A and cooked to perfection. All foods are top quality.

The most surprising part of this whole operation is that we operate at a food and labor cost that most people can't believe, but we are always able to prove our figures. Our cost includes maintenance, repairs and replacements, and never at any time reaches 50 cents per person per meal; actually it is a good deal lower than that.

Julian Pike

C. & O. Hospital
Clifton Forge, Va.

ROVING REPORTER

The Brighter the Better!

A radical departure from the usual muted colors in hospitals has been made by Decorators Sally and Sidney Liberman for the New York Eye & Ear Infirmary, New York City. The clinic of this parent institution of the specialty has been redecorated with bright coral on all the walls, on the theory that bright colors are not injurious to the eyes, even eyes under treatment.

The floor of the clinic is coral and brown with a brown rubber baseboard. Furniture is beige. The windows have a new type of vertical blinds in dark brown to match the baseboards and the coral and brown floors. The accents, such as lamps, are polished brass.

The Libermans designed the nurses' station as well as the combined desk and instrument case for each of the six doctors. These desks are topped with plastic and are lacquered to match.

Examining cubicles and treatment chair are metal, carrying out the same color scheme as the gray-beige of the desks.

The floor is vinyl tile. The walls, too, are covered with vinyl. Because the walls, floor and furniture are designed to be "resistant to everything," the clinic is almost maintenance-free. It now handles 50 per cent more patients than before, because of the placement and planning of the nurses' station, examining cubicles, and treatment chair.

Above: General view of the clinic before remodeling. Below, left: View of new booths and treatment desks; right: vertical blinds control light.

Coatesville Hospital Addition, Coatesville, Pa. Architects: Lawrie and Green, Harrisburg, Pa. Contractor: Wark & Company, Philadelphia, Pa. Photos: Courtland Hubbard, Philadelphia, Pa. Windows: Lupton Aluminum Projected.

. . . the windows will never be patients

With brick walls and Lupton Aluminum Windows, this new hospital addition needs little or no exterior maintenance . . . no periodic refinishing and painting. The sturdy aluminum windows — trim, neat and efficient now — will stay that way, unhampered by thickening paint.

The balanced ventilating sash are engineered to open and close at a touch. Sash-to-frame contact, designed for minimum air leakage, remains constant, undisturbed by clogging paint. Once installed, Lupton Windows are a permanently satisfactory feature. The "ills" that pile up maintenance costs with old-fashioned windows are unknown with Lupton. There is no warping, shrinking, swelling or rattling.

Designed and made by metal window craftsmen . . . backed by 50 years experience in manufacturing metal windows . . . every Lupton Window is a quality product built for a long life of trouble-free service. Hospitals and schools, churches and office buildings all enjoy the advantages of Lupton Metal Windows. In fact, the list of Lupton installations covers the entire country in buildings of every description. From the complete Lupton line, in steel and aluminum windows, it is easy to select the right style, the right size, the right price to "fit" a building and its budget.

Ask for more Lupton facts.

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LUPTON METAL WINDOWS

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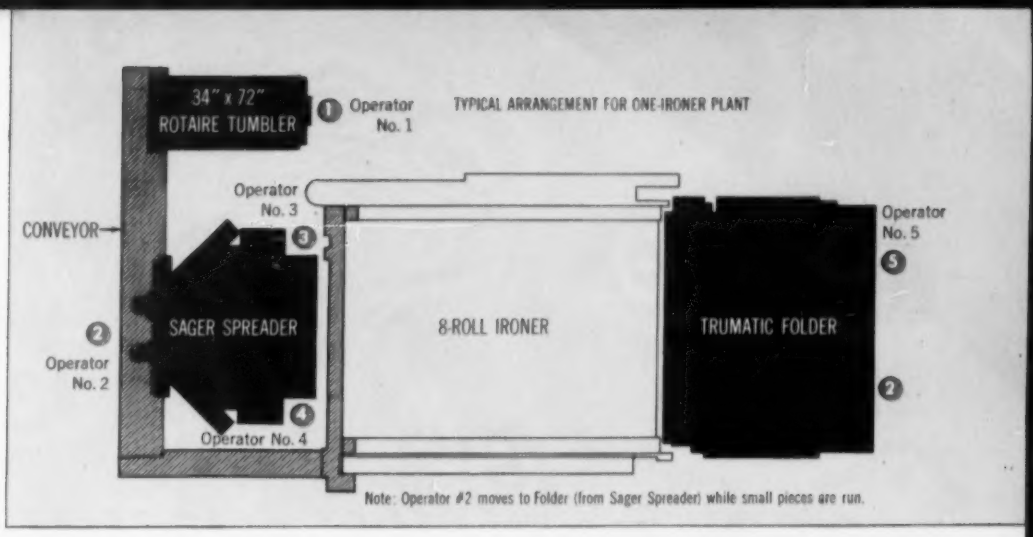
Mechanized flatwork production now a reality for one-ironer plants!

Up to 760 lbs. per hour on both large and small flatwork. The simple addition of these few pieces of American equipment converts your single 8-roll ironer into a high-production flatwork finishing system. Arrangement can be adapted to suit your individual floor space requirements.

34" x 72" Rotaire Tumbler, with 800 lb. per hour dry weight capacity, is job rated to keep 8-roll ironer working at top production. Automatically delivers a continuous flow of warm, properly conditioned flatwork—both large and small pieces. Eliminates slow, costly manual shake-out.

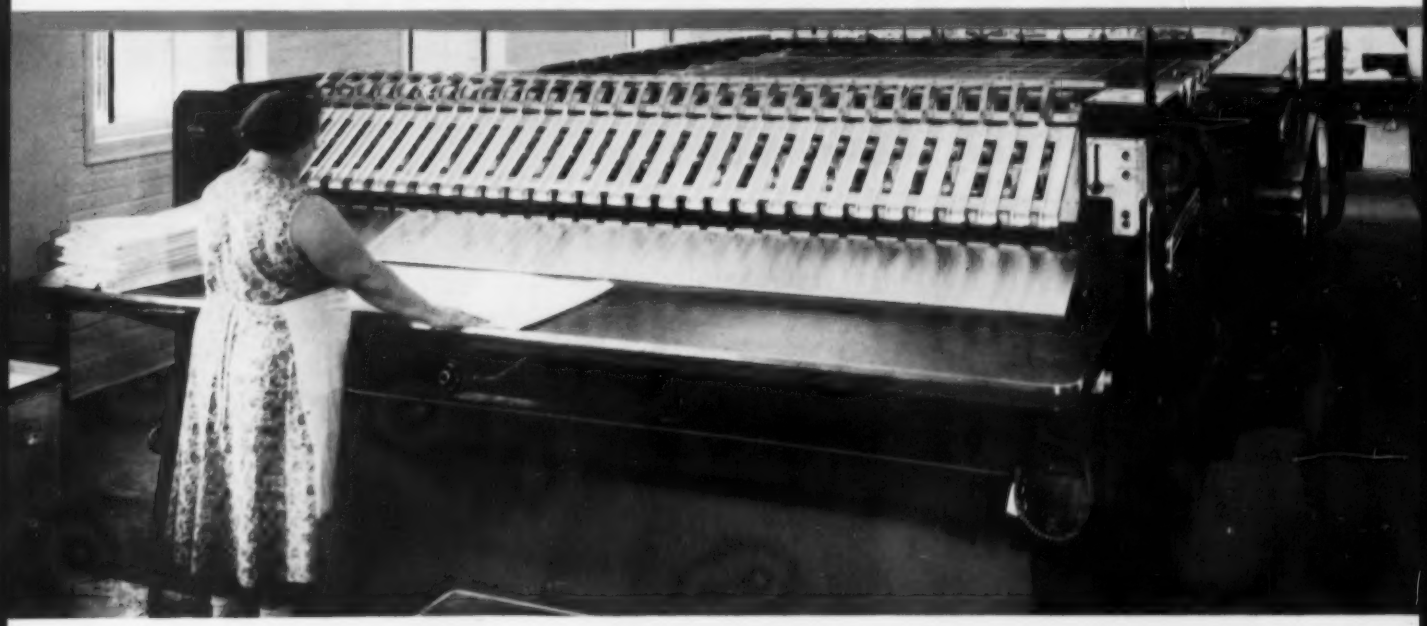
Sager Spreader handles over 700 sheets, spreads or similar large pieces per hour. Enables one girl to deliver more sheets per hour to ironer feeders than three or four hand shakers. Opens up and smooths pieces for fast, easy feeding. Each piece can be quickly inspected as it travels in full view through Spreader.

The American Laundry Machinery Company · Cincinnati 12, Ohio



Five operators are all you need. Here's how a typical one-ironer set-up works. Operator #1 takes extracted work, separates large and small pieces. Feeds large pieces into 34" x 72" Rotaire Tumbler which conditions work. Small pieces are then conditioned in same way. Tumbler automatically delivers work to conveyor. Operator #2 removes large pieces from conveyor, feeds them into Sager Spreader. Small pieces are allowed to travel on to another conveyor which delivers them directly to feeders at ironer. Operators #3 and #4 feed all work into ironer. Operator #5 receives, cross-folds and stacks all finished pieces from Trumatic Folder. On small pieces, Operator #2 shifts her position to assist Operator #5.

Your American Representative is fully qualified to assist you in planning a mechanized flatwork production set-up for either the single-ironer plant or for larger installations. Call, or write today for complete information.



Trumatic Folder automatically quarter-folds sheets, bed spreads, table cloths and smaller flatwork directly from the ironer, at highest ironing speeds. No slowing down for hand folders to keep up. Automatic measuring device assures every folded piece will have neat, even edges. Automatically transfers back and forth from single to two-lane operation. Normally requires only one operator for cross-folding and stacking large flatwork, two operators for small pieces. Independently driven, the Trumatic Folder can be furnished for 110" or 120" chest-type or cylinder-type flatwork ironers.

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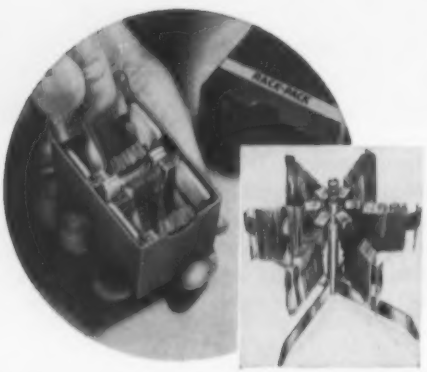
must 'survive' a rigid series of progressive scientific tests to qualify as suitable for surgical use. Those that 'pass' are surgically perfect and uniformly sharp throughout their entire cutting edge. They will remain sharp and useful for longer periods . . . an important factor in economy when yearly volume of purchases is considered.



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Beautiful Bed Signs by Hollister

These are the sure-to-be-seen signs that fasten to the foot of the patient's bed. Boldly printed, colorful reminder cards slide into place in a second under a shatterproof transparent covering. Read next page and accept our no-risk Demonstration Kit offer. Then you'll *know* why so many progressive hospitals are adopting the Hollister Bed Sign reminder system.

Read next page for
NO RISK TRIAL PLAN!

Now see the beauty . . . test the convenience of

Quality Bed Signs by Hollister

Picture above shows ease of changing Reminder Cards in the Hollister Quality Bed Sign. Reminders are printed in bold letters on plastic coated cards. In but a few seconds, nurse selects card from Reminder Card Rack (at left) and inserts it in Bed Sign which is attached to foot of the patient's bed.

FREE This $9.50 Reminder Card Wall Rack (shown at left) given free with your purchase of 50 Hollister Bed Signs. Like the Bed Signs, the rack is made of translucent Plexiglas. 12 pegs hold Reminders in readiness at nurses' station.

Accept this no-risk Hollister Bed Sign demonstration offer

There's no risk at all! If you don't agree that it's the most beautiful, most convenient bed sign ever, you may return the kit for full refund.

Send No Money

Simply fill in and mail the coupon and we'll gladly send you the complete Hollister Bed Sign Demonstration Kit. Includes: 1. One 4-reminder Plexiglas* Bed Sign; 2. Fifteen assorted Reminder Cards; 3. Twenty Patient Name Cards; 4. Descriptive Booklet and Price List.

Note the Beauty

When you receive your kit, notice how the sign harmonizes with any style bed — how well it combines with any decorative plan. Then note how easily the bright, boldly lettered reminder cards slip into place under the protective Plexiglas face. You'll want to let others see and try it too.

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If you're as enthusiastic about these Hollister Quality Bed Signs as others have been, you'll want them for every bed in your hospital. Fill in and mail the coupon below today.

PLEASE SEND:

( ) **Hollister Bed Sign Demonstration Kit, including sign and reminder cards. Price $3.50. Please bill the hospital with understanding Demonstration Kit may be returned within 30 days for refund.**

( ) **Send FREE Bed Sign Catalog and Price List.**

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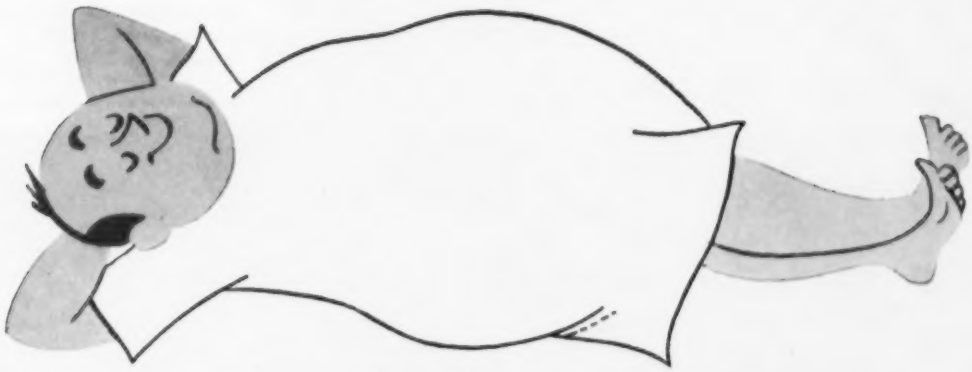
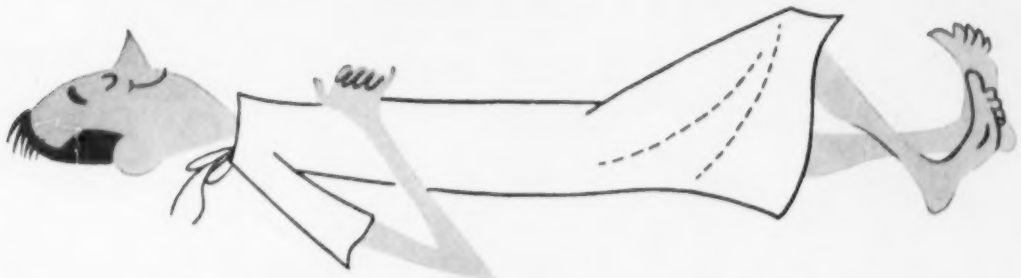
HOLLISTER

FRANKLIN C. HOLLISTER COMPANY
833 N. ORLEANS ST. • CHICAGO 10, ILLINOIS

**Plexiglas is a trade mark of Rohm & Haas Company, Philadelphia. Reg. U.S. Pat. Office and in other principal countries in the Western Hemisphere.*



Fat or lean...they both rest better



on a hospital Beautyrest mattress

Whether your patient is a hefty 250-pounder or a 130-pound lightweight—bulgy or bony—he'll rest more comfortably—get the support he needs—on a hospital Beautyrest* mattress.

The restful inside secret is the *independent action* of each individually pocketed Beautyrest coil. Because the coils are not wired together, as with ordinary mattresses, they resist and support *only* in proportion to the pressure put on them. Result: a firm mattress that yields to varying body weight and body contour.

Unlike coil-less type mattresses, Beautyrest never allows a patient to "touch bottom."

Beautyrest mattresses last longer—as proved by actual tests! For example, one of the weak points of an ordinary mattress is the border. Beautyrest has a "crushproof" border so anchored that it supports the weight of a "bed-edge sitter." And, for bed-making convenience, the weight of the mattress holds down sheets firmly.

For patient comfort—for economy and convenience—your best choice in mattresses is Beautyrest!

** Trade-Mark Reg. U. S. Patent Office*

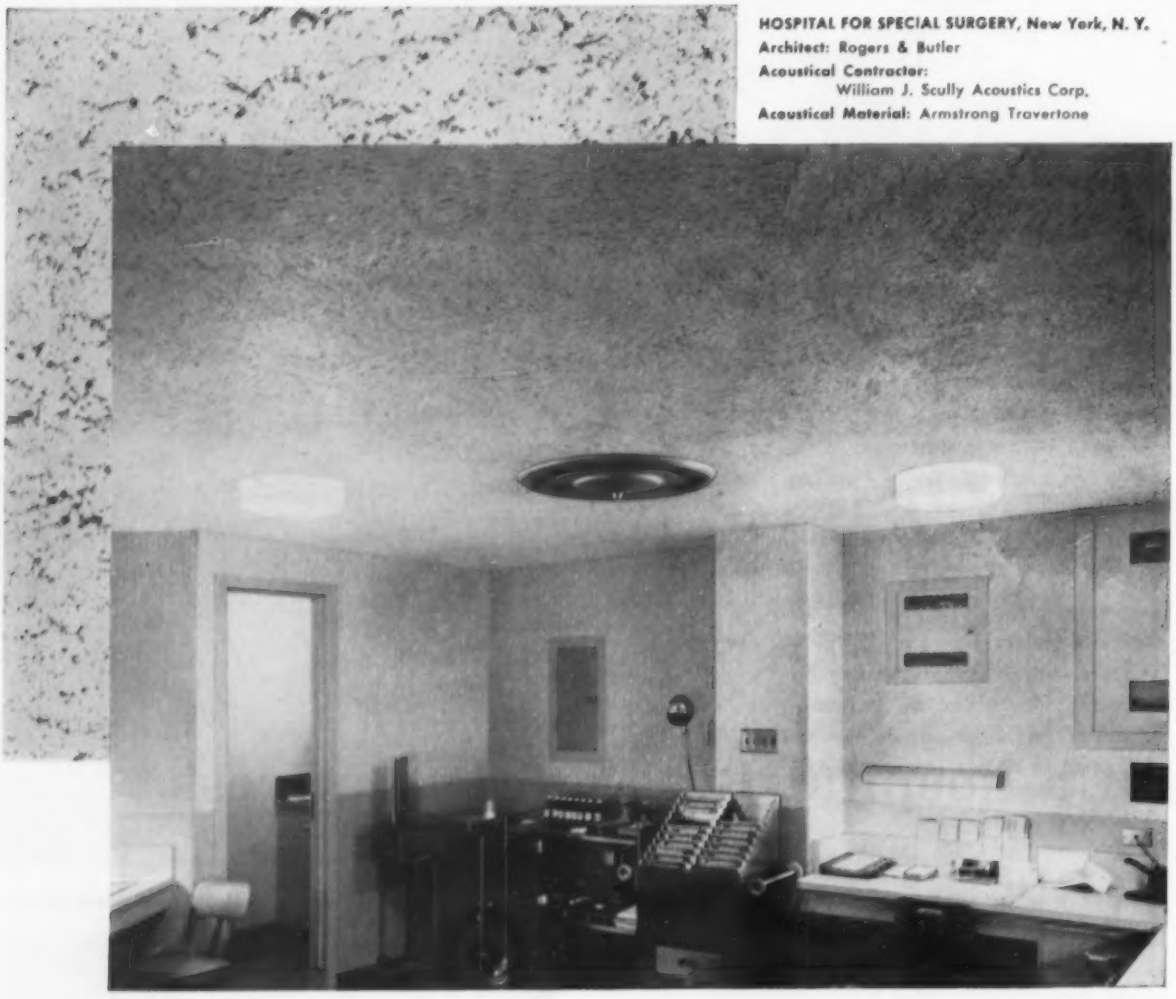
ORDINARY MATTRESS— see how the wired-together coils pull laterally on each other, pulling the whole mattress into a hollow.

BEAUTYREST MATTRESS— in the Beautyrest, only the small, independently pocketed coil, the one pressed, yields — the others remain upright to retain a firm mattress.

SIMMONS COMPANY CONTRACT DIVISION

Beautyrest for hospitals—made only by Simmons

DISPLAY ROOMS: Chicago, New York, San Francisco, Atlanta, Dallas, Columbus, Los Angeles



HOSPITAL FOR SPECIAL SURGERY, New York, N. Y.
Architect: Rogers & Butler
Acoustical Contractor:
William J. Scully Acoustics Corp.
Acoustical Material: Armstrong Travertone

Attractive ceiling quiets hospital noise center

Often located at the junction of two corridors, always bustling with activity, the nurses' station is frequently the noise center of a hospital. This important work center resounds with disturbing, distracting sounds—ringing telephones, rattling metal and glass equipment, chattering visitors.

To combat this annoying noise problem, plans for almost all new hospital construction or remodeling call for acoustical treatment. At New York's new Hospital for Special Surgery, for instance, the nurses' stations are sound conditioned with noise-quieting ceilings of Armstrong Travertone. Travertone's high acoustical efficiency muffles distracting sounds in corridors and offices, too, and its distinctive, fissured surface has made it an especially attractive ceiling for patients' lounges, cafeteria, and clinic as well.

Completely fire-safe . . . Incombustible, Travertone meets even the strictest building codes, adding an extra measure of fire protection for patients and staff.

Economical to maintain . . . You can keep Travertone new looking for years by cleaning or repainting when necessary. In addition, it forms a permanent ceiling that will not crack.

Light reflective . . . Travertone's smooth, white finish has high light reflectivity, providing evenly diffused, glare-free illumination.

Free booklet, "Quiet at Work," shows how sound conditioning can work for you by increasing comfort and efficiency. Ask your Armstrong Acoustical Contractor for a copy or write Armstrong Cork Company, 4207 Union St., Lancaster, Pa.

Armstrong

ACOUSTICAL MATERIALS

Cushiontone® • Travertone* • Crestone* • Minatone®
Arrestone® • Corkoustic® • Perforated Asbestos Board

* TRADE-MARK

Troy Fullmatic® Washers save time and labor through automatic controls and "Slyde-Out"® unloading shelf.

St. John's cuts laundry costs . . . thanks to Troy's Survey Service

St. John's, Tulsa, took full advantage of Troy's laundry planning service during their recent expansion to 650 beds.

Working in cooperation with the architect, Troy engineers made a scale drawing of the laundry area, placing cutouts of Troy's automatic machinery along predetermined lines of work flow. Additional washing and finishing machinery was selected according to formula.

The completed installation has resulted in operating cost reductions, and is capable of handling all new peak loads without overtime. Find out about Troy's free Survey Service . . . while *your* laundry is in the planning stage.

A Troy Fleximatic Folder takes work direct from a Troy 8-roll ironer . . . automatically measures and folds linens into quarters.

Inner basket of this Troy 54" Olympic Extractor is removed by hoist . . . saves hours of unloading time.

Troy

LAUNDRY MACHINERY

Division of
American Machine and Metals, Inc.
EAST MOLINE, ILLINOIS

"World's oldest builders of power laundry equipment"

MAIL COUPON TODAY

TROY LAUNDRY MACHINERY
Division of American Machine and Metals, Inc.
Dept. MH-756, East Moline, Illinois

☐ I wish details on your free Survey Service. This does not obligate me in any way.

Send free catalog on: ☐ Fullmatic Washer ☐ Olympic Extractor ☐ Fleximatic Folder ☐ Speedline Flatwork Ironer

COMPANY

ADDRESS

CITY ZONE STATE

ATTENTION MR.

Calling Dr. Killaire . . . *quietly!*

In any hospital the rapid location of staff members and visiting doctors is of prime importance. The larger the hospital and the number of doctors, the more essential it is to overcome this problem without annoyance to patients and others. Voice paging through loudspeakers is frequently found objectionable because it disturbs patients and ties up the telephone operator's time. The great majority of hospitals, therefore, utilize the silent "flashing light indicator" types of doctor paging systems.

These systems cause no annoyance to patients and greatly simplify the telephone operator's work. Efficient and economical, they permit the operator to page from three to six doctors simultaneously, and consume no more of her time than is required to press four buttons whenever she initiates a call. She usually gets her man...quickly and quietly.

Auth
SINCE 1892

For many years the Auth Electric Company has developed and produced fine hospital signaling and communication systems. These include Nurses' Call, with or without voice communication between patient and nurse; Staff Register (In and Out); and Doctor's Paging Systems. Whenever finer signaling systems are designed, Auth will produce them.

Manufacturers of
ELECTRICAL SIGNALING, TIME AND COMMUNICATION SYSTEMS FOR HOSPITALS, SCHOOLS, HOUSING, INDUSTRY AND SHIPS

Auth Electric Company, Inc.
LONG ISLAND CITY 1, NEW YORK

Here's the secret

to save your hospital  *time and money. It's DICTABELT*  *exclusive record of the Dictaphone TIME-MASTER dictating machine.*  *DICTABELTS are crystal-clear, unbreakable, mailable, filable, economical ... help your staff "write" diagnoses, notes, reports, etc. the easiest way.*

Send for booklet  *"Communication."*

DICTAPHONE *Corporation, Dept. MH*
420 Lexington Ave., New York 17, N.Y.

In Canada, write Dictaphone Corporation, Ltd., 204 Eglinton Ave. East, Toronto ... in England, Dictaphone Company, Ltd., 17-19, Stratford Place, London W.1. Dictaphone, Time-Master and Dictabelt are registered trade-marks of Dictaphone Corporation.

NEW TENSOR DOESN'T "DIE" IN THE DRYER

Elastic bandage made with ordinary rubber can't stand the heat of the dryer. Rubber threads deteriorate and bandage becomes useless, incapable of giving controlled support. That's because ordinary rubber "dies" in the dryer.

Even after 280°F. heat of the dryer, TENSOR elastic bandage *stays* elastic . . . the only bandage that does so. Unlike bandages made with ordinary rubber, TENSOR will still give proper support *after* repeated heat-drying. TENSOR, you see, is woven with *heat-resistant*, live rubber threads.

NEW TENSOR®

ELASTIC BANDAGE

WOVEN WITH HEAT-RESISTANT LIVE RUBBER THREADS

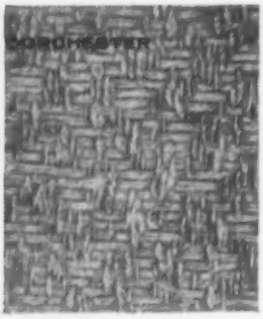
BAUER & BLACK

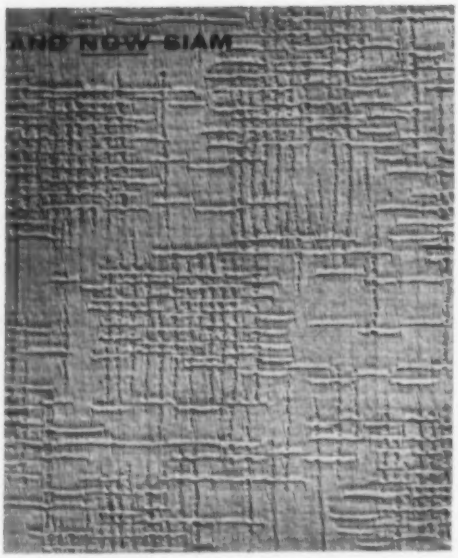
Division of The Kendall Company
309 W. Jackson Blvd., Chicago 6, Ill.

Du Pont Presents

a stunning selection of vinyl upholstery patterns in

Breathable Fabrilite®





THE FAR EAST LOOK—formerly a high-fashion exclusive of luxury fabrics—is now available in extra-durable vinyl upholstery. Siam—newest pattern in Du Pont breathable "Fabrilite"—breathes with the very air of the Orient. Its delicately worked design gives the effect of pongee, and its unusual grain has the rich texture of raw silk. Siam is executed in lustrous, *fade-resistant* Jewel Tone† colors—ten compatible metallic tints (including for the first time a true gold color) that will brighten any room. The result of years of research, Jewel Tone colors are available only in Siam breathable "Fabrilite." Their *fade-resistant* characteristic assures the color's lasting the life of the extra-rugged vinyl! †Patent Applied For.

ONLY BREATHABLE "FABRILITE" OFFERS ALL THESE ADVANTAGES—

- √ Thousands of invisible pores that breathe for floating-on-air comfort
- √ Continuous vinyl coating that leaves no exposed fabric to soil
- √ Exclusive Du Pont finish that resists dirt and wear... washes completely clean with a soapy sponge

NOW YOU CAN ENJOY high-style upholstery that provides *both* the cleanability and durability of vinyl plastic and the airy comfort of a woven fabric! All three patterns in breathable "Fabrilite"* have the exclusive Du Pont plasticizer system which takes full advantage of its elastic knitted-fabric backing. Besides comfort and durability, the result is an easy-to-clean seating surface that stays pliable and retains its original shape.

And each pattern possesses its own distinctive design! Castleton was created by world-famous Russel Wright as a "living" abstraction. The pattern** actually changes when viewed from different angles—subtle overtones and striking contrasts appear in unusual combination. Styled in 15 exciting deeptones and pastels.

Dorchester presents the quality appearance of luxurious hand-loomed tweed. Its fine twilly texture enhances every setting—from waiting room to dining room. The introduction of Siam—with its seductive Far East look—provides still a third choice of a strikingly different pattern to suit your décor.

Castleton, Dorchester, Siam—their extra durability, extra comfort, extra-protective beauty will prove there's no vinyl upholstery like Du Pont breathable "Fabrilite."

E. I. du Pont de Nemours & Co. (Inc.), Fabrics Division, Wilmington 98, Del.

*"Fabrilite" is Du Pont's registered trademark for its elastic-supported vinyl upholstery. **Design Patent 175,817.

Blow smoke right through it! Visual proof (above) shows you that breathable "Fabrilite" upholstery really breathes for the utmost in comfort!

There's no vinyl upholstery like Du Pont *Breathable*

Fabrilite®

elastic-supported vinyl upholstery

DU PONT

REG. U. S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING...*THROUGH CHEMISTRY*

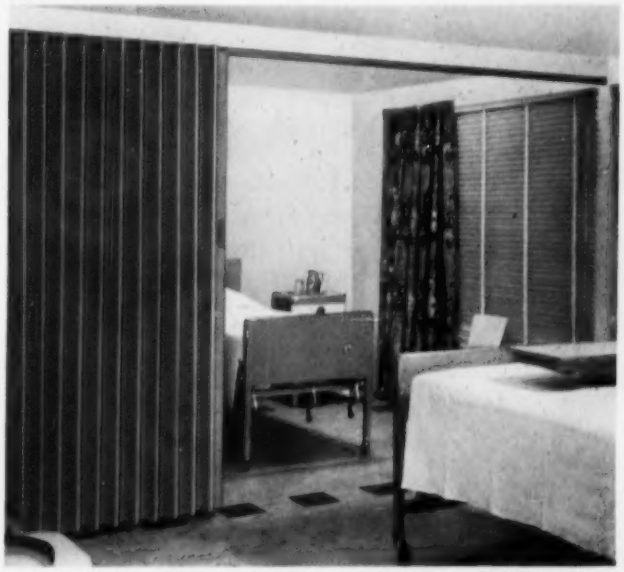
Like to get the capacity of two rooms in the space of one?

Modernfold doors quickly divide multiple rooms or wards into semi-private rooms

MODERNFOLD Doors increase your capacity at low cost, and *still* give every patient the privacy and quiet that he needs.

These doors fold or unfold in *seconds* to give you space custom-tailored to your needs at any moment.

They're rugged, easily washed and come in dozens of cheery colors. Consult your MODERNFOLD distributor; from the initial planning to final installation, he can help you to use your space more efficiently.



Mounted on overhead tracks, a MODERNFOLD Door can double the capacity of this private room almost instantly. When not needed, it folds compactly away.

Here MODERNFOLD can make space more versatile... save on costly remodeling.

NEW CASTLE PRODUCTS, INC.
Dept. G57, New Castle, Indiana
(In Canada, New Castle Products Ltd., Montreal 6)

Please send me full information on MODERNFOLD Doors.

NAME _____

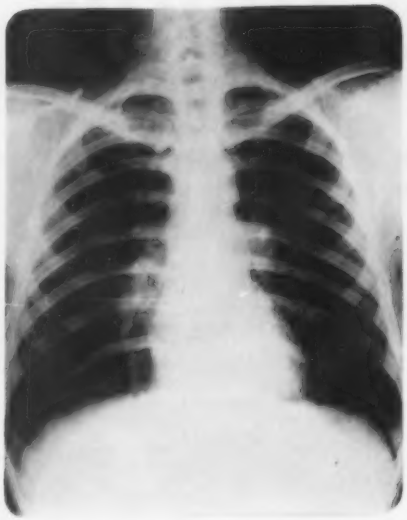
BUSINESS ADDRESS _____

CITY _____ ZONE _____ STATE _____

modernfold®
DOORS

MODERNFOLD Distributors are listed under "Doors" in city classified telephone directories.

smallest cost rules the others



films for diagnosis: **72c each**
costs if X-rays repeated: **$3.50 each**
pneumonectomy (tumor): **$971.26**
life of patient: **priceless**

T.B. or tumor? Medicine or surgery? In this hospital, as in many others, the first of several life-saving decisions is the radiologist's differential diagnosis. And he constantly depends on clear, faithful-to-image Ansco x-ray films to reveal fine differences.

Rate *diagnostic values* above price in choosing Ansco High Speed x-ray Films for every diagnostic problem. Quality is uniform. Ansco x-ray films are always:

- tested physically for base strength, flexibility and dimensional stability
- *tested photographically* for sensitivity—so that bones and tissues show with unexcelled clearness
- *tested repeatedly for uniformity* long after film has left the factory

Subtract costs with super sizes of Ansco films and chemicals

Ansco High Speed X-ray Films assure constant high fidelity to image. Buy: Packages of 25 sheets and 75 sheets.

Liquadol Developer works faster, lasts longer, than powder. Buy: 1 gal. 5 gal. 20 gal.

Liquadol Replenisher more than doubles the life of Liquadol Developer. Maintains constant developing time. Buy: 1 gal. 5 gal. 20 gal.

Liquafix (Liquid) provides positive fixing-hardening action. Buy: 1 gal. 5 gal.

Powdered X-ray Fixer is non-staining. Buy: 1 gal. 5 gal. 20 gal. 50 gal.

Ansco Binghamton, New York. A Division of General Aniline & Film Corporation.

BEFORE AUTOCLAVING. Here is what "SCOTCH" Brand Hospital Autoclave Tape looks like on bundles ready to be put in the autoclave.

AFTER AUTOCLAVING. These unmistakable markings tell you the pack has been through the autoclave. There is no possibility of error. The special inks used in this tape must be *intentionally activated*, and

Only high steam temperatures can do it!

No danger that sunlight or radiator heat will bring out the distinctive stripes on this foolproof tape. When you see them on an autoclave pack (and they can be seen clear across a room) you're sure that pack has been through the autoclave. *This is not positive proof of sterility, of course—nothing on the outside of a bundle can prove that.*

Seals packs firmly in half the time required for pinning, tying, or tucking! "SCOTCH" Hospital Autoclave Tape No. 222 holds in high steam temperatures, leaves no stains or gummy residue, can be written on with pencil or ink.

REG. TRADEMARK

SCOTCH
BRAND

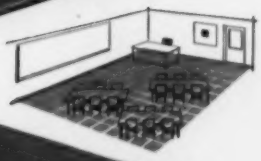
Hospital Autoclave Tape No. 222

Your surgical supply dealer has this time-saving, work-saving tape now . . . See him right away!

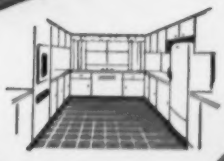
The term "SCOTCH" and the plaid design are registered trademarks of Minnesota Mining and Mfg. Co., St. Paul 6, Minn. Export Sales Office: 99 Park Ave., New York 16, N.Y. In Canada: P.O. Box 757, London, Ontario.

there's

more



VINYL



in every tile of

Bolta Floor

FOR HOSPITALS
SCHOOLS • OFFICES
THEATRES • HOTELS
MOTELS • APARTMENTS
BANKS • HOMES

WEARS LONGER,
WITH OR WITHOUT WAXING

Because of its high percentage of vinyl, the more dense surface of Bolta-Floor has greater wearability, easier maintenance . . . will retain its rich natural lustre years longer, with or without waxing.

Bolta-Floor is produced in a full range of 22 fashionable decorator colors . . . 5 solid and 17 marbleized. It's available in 4 tile sizes (6 x 6, 9 x 9, 12 x 12, 18 x 18), 2 roll widths (27" and 54") and in 3 gauges (⅛", 3/32" and .080 gauge).

To be sure of finest quality vinyl flooring with assured top performance, specify Bolta-Floor —another superior product of The General Tire & Rubber Co.

The General Tire & Rubber Co.
Flooring Division · Akron, Ohio

GRACE HOSPITAL, HUTCHINSON, KANSAS

DOW

Question:

Why do modern hospitals prefer latex paints?

Answer:

Easy application? Fast dry? Or something else?

Hospital "A" reported smooth, uniform finish. Not a brush or lap mark anywhere!

Hospital "B" heard about it . . . and discovered latex paints left no painty odor. Rooms were used the same day they were decorated!

Hospital "C" found recently painted surfaces can be touched-up easily.

Hospital "D" joined the trend to latex paints . . . and liked the quick clean-up. Brushes and rollers rinsed clean in tap water. And low-cost brushes did as well as expensive ones!

Hospital "E" discovered the two-way durability: latex paints stand up well under sun and strong lights. The smooth surface is unharmed even when scrubbed with disinfectants.

So it goes. You, too, will find many benefits for your hospital. Today 37% of *all* hospitals use these paints!

Leading manufacturers make paints with Dow latex. For information, contact Plastics Sales Department PL593W, THE DOW CHEMICAL COMPANY, Midland, Michigan.

LATEX T.M.

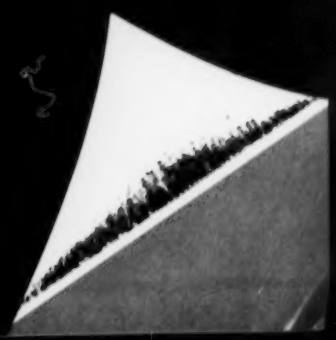
DOW

you can depend on

DOW PLASTICS

How CECO PRODUCTS CONTRIBUTE TO PATIENT COMFORT

IN THE HOSPITAL OF THE YEAR



6 words that spell comfort in a hospital...

Less Noise
Proper Daylighting
Good Ventilation

...and Ceco building products make all this come true

Patient comfort always is a consideration in the building of a hospital. But when architect Leo A. Daly designed the Bishop Clarkson Memorial Hospital, Omaha, Nebraska, *special emphasis* was given that factor. Hal G. Perrin, administrator, and Robert H. Storz, chairman of the building committee, consulted with architect Daly . . . patients were queried . . . all agreed that noise, daylighting and ventilation should come in for critical study. The soundproof characteristics of Ceco-Meyer Concrete Joist Construction and the daylighting and ventilating advantages of Ceco Windows met the requirements. Architect Daly made this further comment on the building method: "This construction is light in weight, but affords exceptional stiffness because of additional depth provided by the monolithic floor and joist section."

Bishop Clarkson Memorial Hospital, selected as the "Hospital of the Year." Leo A. Daly Co., Architects and Engineers; Peter Kiewit Sons' Co., Contractors

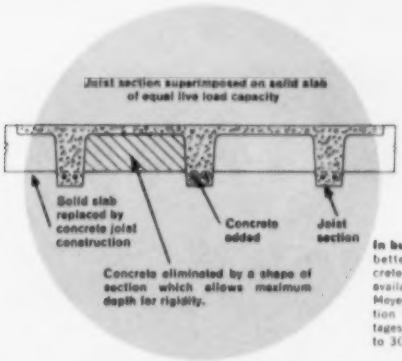
Ceco Steel Double-Hung Aluminum Windows got the call for better daylighting because glass areas are bigger . . . mullions sleeve together. The windows are tight, a factor in efficient air-conditioning . . . they operate silently and are easy to maintain. Ceco helped the contractor maintain a fast pace of construction by coordinated deliveries of reinforcing steel, steelforms and windows. For your next project, consult Ceco Engineers. You can be sure of counsel and service to aid you in adapting the right building product to your particular problem.

CECO STEEL

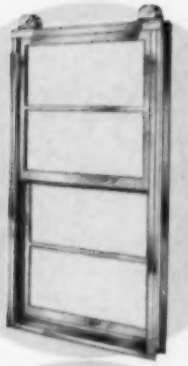
CECO STEEL PRODUCTS CORPORATION

Offices, warehouses and fabricating plants in principal cities
General Offices: 5601 West 26th Street, Chicago 50, Illinois
Windows, Screens and Doors / Ceco-Meyer Steelforms / Concrete Reinforcing / Steel Joists / Metal Roof Deck

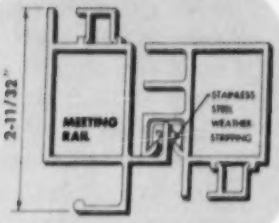
In construction products Ceco Engineering makes the big difference



In buildings, there's nothing better than reinforced concrete . . . rugged, firesafe and available now. In floors, Ceco-Meyer Concrete Joist Construction brings you these advantages . . . with savings of 10% to 30% in concrete and steel.



Ceco-Sterling Series 200-B Window — Ceco-Sterling Double-Hung Windows assure minimum air infiltration. Sash float on stainless steel weatherstripping, providing tight but easy-operating, silent windows.



Meeting Rail Section, Series 200-B Window — Heavy extruded box sections assure rugged performance . . . double-contact stainless steel weather-stripping provides tightness. Weatherstrip at jambs gives a spring cushion sliding contact.

Concrete visors for shading and window washing are dramatized in this view. Shaded windows are Ceco-Sterling Double-Hung Aluminum Windows and Picture Windows.

CECO'S COAST-TO-COAST NETWORK OF

SALES OFFICES AND WAREHOUSES

Albuquerque, N. M., 141 Jackson, N. E.
Atlanta 9, Ga., 1401 Peachtree St., N. E.
Birmingham 7, Ala., 3500 27th Ave., N.
Bridgeport 6, Conn., 3672 Main St.
Charlotte 1, N.C., 314 W. Trade St.
Chicago 50, Ill., 1926 S. 52nd Ave.
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Cleveland 15, Ohio, 1621 Euclid Ave.
Dallas 1, Texas, 6810 Harry Hines Blvd.
Denver 2, Colo., 4201 Brighton Blvd.
Des Moines 9, Iowa, 404 Hubbell Bldg.
Detroit 1, Mich., 912 Fox Theater Bldg.
Hillside 5, N.J., 625 Glenwood Ave.
Houston 10, Texas, 1902 Weber St.
Indianapolis 2, Ind., 1538 N. Meridian St.
Jacksonville 3, Fla., 115 Park St.
Kansas City 6, Mo., 602 Pickwick Bldg.
Los Angeles 23, Calif., 1450 Mirasol St.
Milwaukee 2, Wis., 756 N. Milwaukee St.
Minneapolis 13, Minn., 2900 E. Hennepin Ave.
New Orleans 13, La., 1040 St. Charles Ave.
Oklahoma City 6, Okla., 1225 Linwood Blvd.
Omaha 1, Nebr., 1141 No. 11th St.
Peoria 7, Ill., South Bartonville
Philadelphia 3, Pa., 1700 Walnut St.
Pittsburgh 36, Pa., 1501 Lebanon Church Rd.
San Antonio 5, Texas, 2414 Transit Tower
San Francisco 24, Calif., 401 Tunnel Ave.
St. Louis 17, Mo., 8310 Eager Road
Washington 27, D. C., 1701 47th Ave., N. E.

CECO STEEL

CECO STEEL PRODUCTS CORPORATION

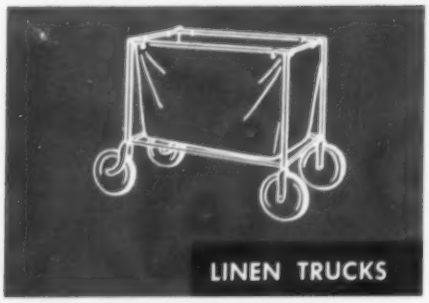
Offices, warehouses and fabricating plants in principal cities
General Offices: 5601 West 26th Street, Chicago 50, Illinois

Windows, Screens and Doors/Ceco-Meyer Steelforms/Concrete Reinforcing
Steel Joists/Metal Roof Deck/Metal Lath

IN CONSTRUCTION PRODUCTS CECO ENGINEERING MAKES THE BIG DIFFERENCE

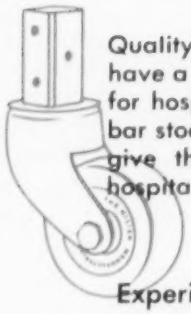
Silent! Dependable!

KILIAN Ball-Bearing Casters



The only caster with proven performance for outstanding . . .

HOSPITAL SERVICE



Quality built for continuous performance, Kilian casters have a record of use that makes them the natural choice for hospital service. All metal parts are machined from bar stock and all ball bearing parts fully heat treated to give the long life and trouble-free service vital for hospital use.

Experiences of hospitals equipped with Kilian casters give adequate proof of the smooth-rolling, lasting dependability that can be expected.

—Fine new institutions like the Hospital for Sick Children in Toronto, for example. When the hospital was opened, every bed, cot, and mobile equipment were fitted with Kilian casters—backed by a five-year guarantee. Typical of the durability built into each Kilian caster, NOT ONE FAILURE WAS REPORTED IN FIVE YEARS OF CONSTANT USE.

You can profit from the experiences of institutions like the Hospital for Sick Children—by selecting the caster that has won its reputation through proven performance

KILIAN *Casters*

THE ONLY CASTER GUARANTEED TO GIVE A MINIMUM OF FIVE YEARS OF DEPENDABLE, TROUBLE-FREE SERVICE

WHY? SEE OTHER SIDE . . . . . →

KILIAN *Ball Bearing* CASTERS

Guaranteed Performance is Built Into Every Kilian Caster

SILENT POSITIVE SWIVELING

to provide safe, easy movement —

Ideally suited for hospital service, Kilian casters are uniformly processed to include features that result in positive swiveling, and easy, quiet rolling action. A self-contained swivel bearing in the forks eliminates the possibility of loosening of the bearing and loss of steel balls. In the wheels, ball bearings instead of plain metal bushings reduce friction and contribute to better and sure, easy movement.

STRONG, DURABLE STRUCTURE

to eliminate time-consuming maintenance problems . . .

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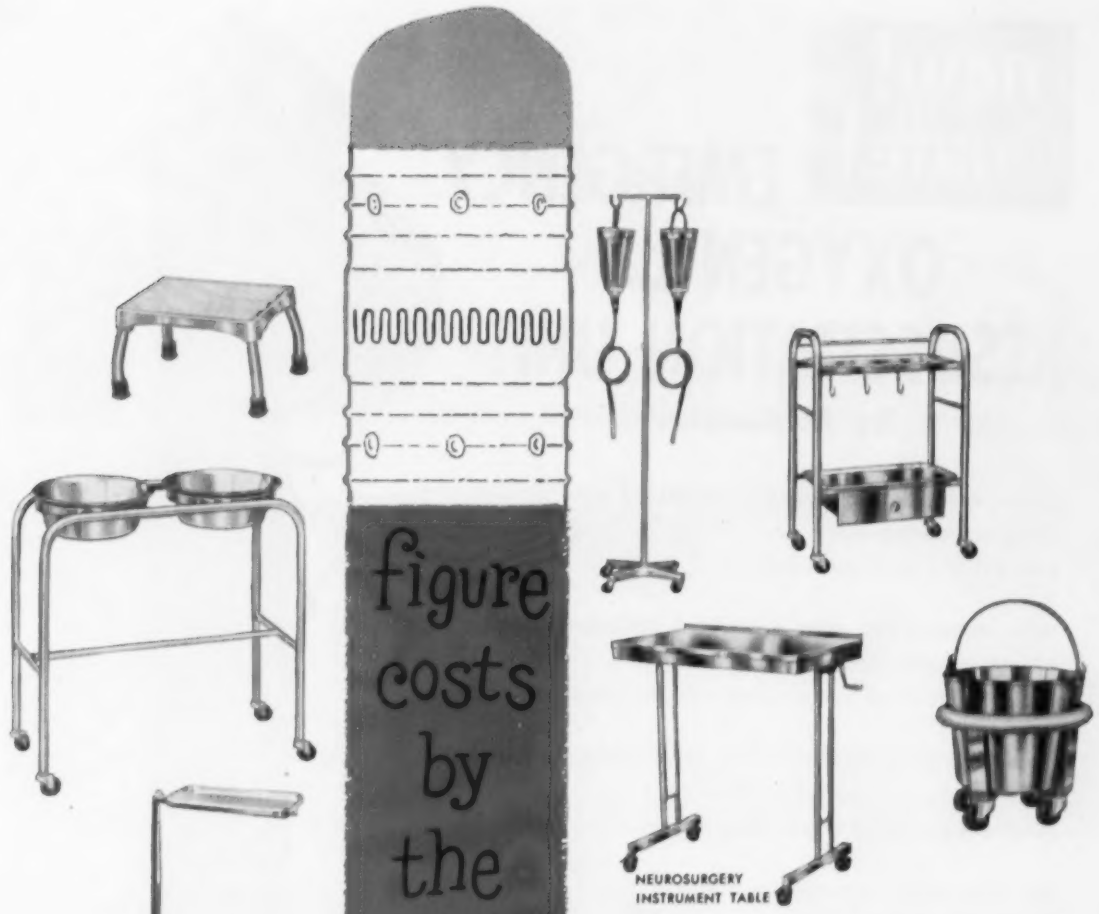

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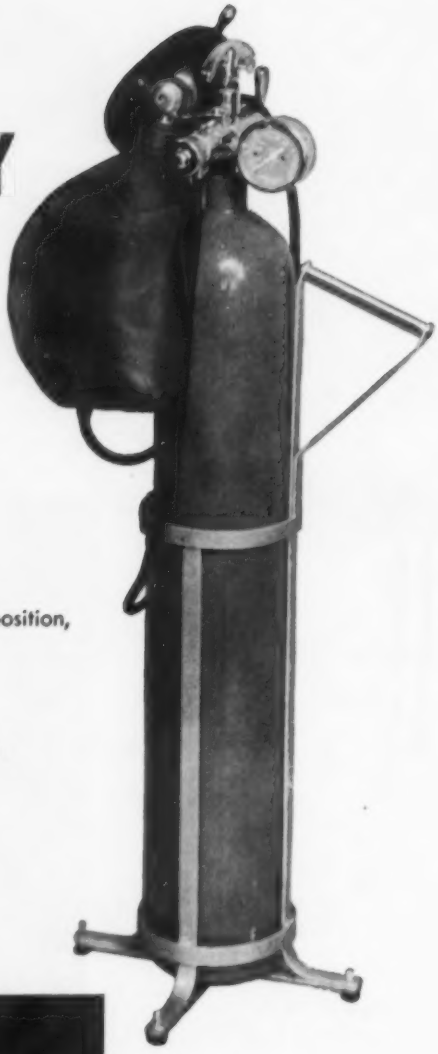

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1. Bogash, R.C., and Pisanelli, R.: Hosp. Management 80:82 (Nov.-Dec.) 1955. 2. Hunter, J.A., et al.: Hosp. Management 81:82 (March) 1956. 3. Hunter, J.A., et al.: Hosp. Management 81:80 (April) 1956.

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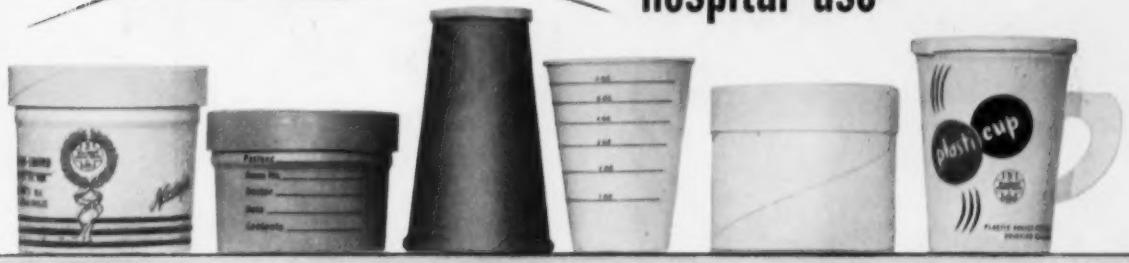

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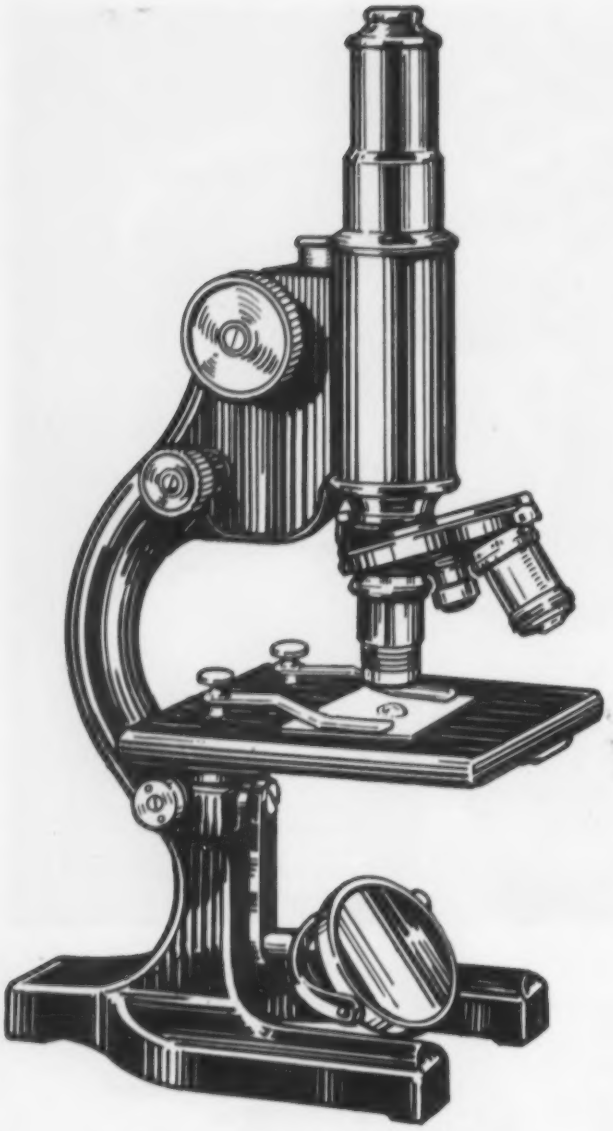

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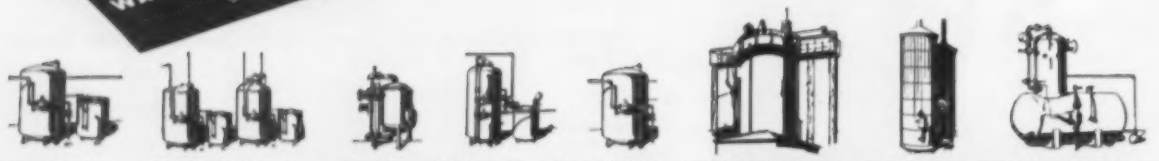

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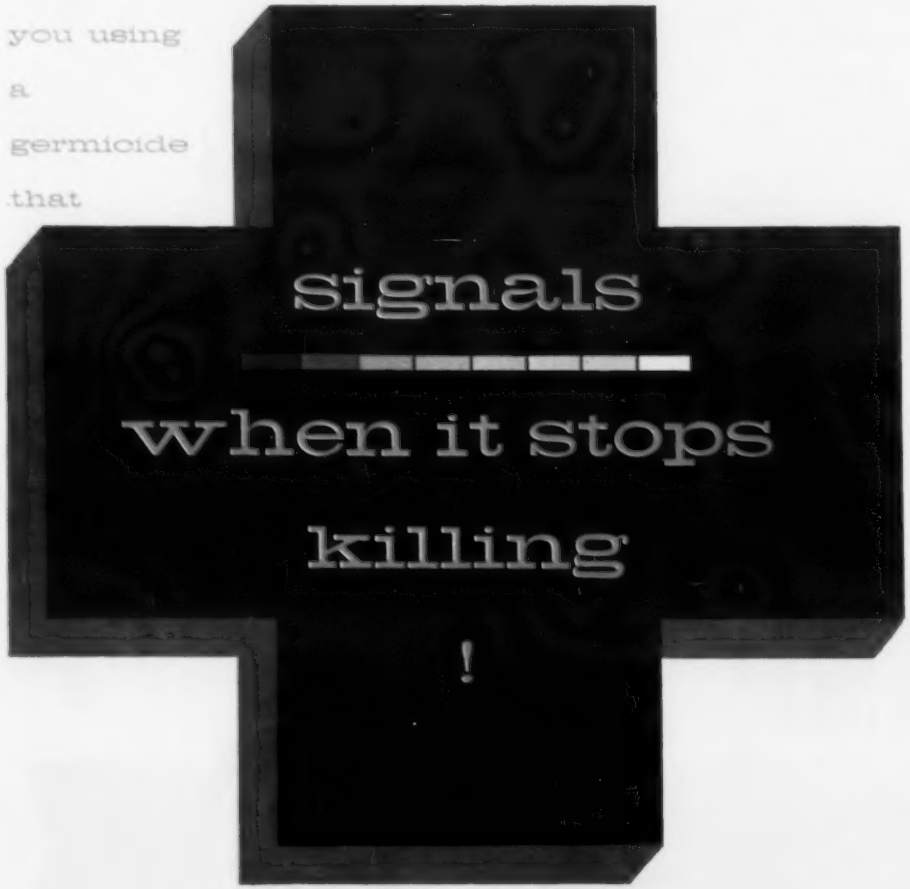

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SMALL HOSPITAL QUESTIONS

Cost of Medical Records

Question: A doctor in our community who is opposed to accreditation and medical records and thinks "the hospital is telling him how to practice medicine" has been stating publicly that hospitals spend 5 or 10 per cent of their income keeping records, many of which he claims are unnecessary. Our own medical record library expense is only approximately 1 per cent of total operating expenses. However, before making this figure public, I'd like to make certain it is in line with record room expense in other hospitals. Is it?—D.K., Ore.

ANSWER: It is.

He'll Probably Earn It

Question: We are a 50 bed hospital in a small community, and the superintendent who has been with us for many years is looking forward to retirement within a few months. In looking for a new administrator, we have been concerned about the salary we are going to have to pay for a qualified person. In fact, it appears we will have to pay a great deal more than we have been paying our administrator in the past, and more, perhaps, than many trustees on the hospital board are accustomed to earning in their own businesses.—C.I.H., Colo.

ANSWER: Is that bad?

Doctors Come First

Question: We have a very limited amount of parking space, and with many of our staff doctors spending the greater part of their day at the hospital, there is little space left for hospital employes who drive to work, and none at all for visitors, who must find on-street parking space, sometimes as much as two or three blocks from the hospital, as we are in a congested area. Recently a visitor who has been an important contributor to the hospital complained and requested that some space in the parking lot, at least, be held for visitors. Do you think this should be done?—W.S.S., Pa.

ANSWER: No. The doctors certainly come first where parking privileges are concerned—not simply as a matter of convenience to them, but primarily because service to patients requires that parking space for doctors should be quickly accessible. If there is positively no room for expansion in your present location, maybe your important contributor would consider making it possible for the hospital to construct a two or three level parking garage in the existing space. You might then charge for visitors' parking, making some return on the capital expenditure.

Ratio of Private Rooms

Question: We are a 100 bed hospital. At present, our patient accommodations are divided as follows: We have 10 beds in private rooms, 42 beds in semiprivate rooms, and 48 beds in wards. The wards have four beds, for the most part; there are two rooms with six beds each. We are now planning an addition that will give us about 40 additional beds when the program is completed, and we should like to know if hospitals of this size commonly maintain about this same distribution of beds in various types of accommodation.—A.P.O., Neb.

ANSWER: The proper distribution among beds in various types of accommodation in any instance depends on the preference and economic situation of the individual institution's clientele. This is such an important decision that it would seem to be essential to make a careful study of these factors in your community before going forward with building plans involving a major investment and establishing hospital conditions over a long period of years. Generally speaking, the trend in recent years has been rather definitely toward an increase in the proportion of private rooms, as opposed to semiprivate and ward accommodations. However, in two or three recent surveys there have been indications in the other direction, and it is possible that in some instances the emphasis on private rooms has been unwarranted. If you are not in a position to make a study of these factors in your community, it may be that you can obtain assistance from public or private welfare agencies, Blue Cross, or others who may be interested in the economic future of the community as it relates to health facilities.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Safe Limits for Receivables

Question: In using the standard measurements for determining whether or not accounts receivable are within safe limits, is it customary to deduct the allowance for bad debts from the total of receivables, using the net figure, or should we use the total receivables without any allowance? Obviously, we might be within safe limits by the former method, and beyond it by the latter, so we should appreciate knowing which method is customarily used.—P.K.S., Ohio.

ANSWER: The figure to be used is the net amount—that is, the total of accounts receivable less the regular amount that is written off for uncollectible accounts.

"Break Even Point" Is High

Question: Study of our financial operations shows that our "break even point" is near 85 per cent occupancy. In conversation with other hospital administrators, I get the impression this is rather high. What is the usual point of occupancy at which hospitals of this size (65 beds) begin to show a profit? —J.T.M., N.J.

ANSWER: The percentage of occupancy at which operating revenue equals total operating expense depends on so many conditions and situations in the individual hospital that it is difficult, if not dangerous, to generalize. It is true, however, that 85 per cent is an unusually high "break even point." In most institutions, this occurs somewhere in the area of 60 to 70 per cent occupancy. It may be your institution is overstaffed, or your rates are not as high as they should be. It would appear worth while for you to compare operations closely with established standards for institutions in this classification.

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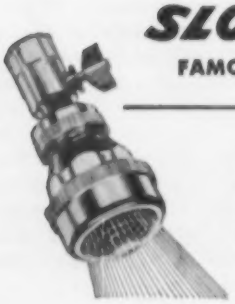

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INTERNAL REVENUE TANGLE

Internal Revenue Service is in the middle of a scrambled situation that I.R.S. admits the courts will have to unscramble.

It all grows out of the Ford Foundation grants. The Foundation, itself tax exempt as nonprofit, sought carefully to limit its gifts to institutions of similar tax status. This led back to the Internal Revenue Service's definition of nonprofit, tax-exempt hospitals.

The I.R.S. specified the usual and well understood requirements for a nonprofit hospital, such as no monetary profit to be realized and a certain but variable amount of free or low-cost service. There would be no particular problem in interpreting these requirements.

But then I.R.S. added a further qualification, that the hospital "must not restrict the use of its facilities to a particular group of physicians and surgeons such as a medical partnership or association, to the exclusion of all other qualified doctors."

I.R.S. explains that it appreciates that physicians on a hospital staff must themselves exercise some control or supervision over doctors admitted to practice in the hospital, but the ruling leaves at least as many questions as it answers.

Who are "qualified doctors"? Those who are licensed to practice medicine in a state, or those the hospital staff accepts as qualified? At what stage will a "medical partnership or association" assume monopolistic tendencies?

I.R.S. is attempting to draw up a more realistic interpretation of what it means, but at this stage is not ready to make any further announcement. Until it is, cases will be considered individually and any hospital that believes it is being treated unfairly will have recourse only to the courts.

FATE OF THREE BILLS UNCERTAIN

With Congress moving up toward its scheduled adjournment date of July 10 to 15, it's touch and go for three pieces of legislation of major interest to the hospital industry.

House hearings have been held on a thrice revised bill for health insurance for U.S. civilian employes; it is being pushed hard, but its prospects of success appear only fair.

A bill for construction grants to medical schools and hospitals for research facilities has passed the Senate, been reviewed by the House committee, and is in a race against time.

The "Little Omnibus Health Bill" is perhaps of the greatest importance, because among other things it contains a provision extending the Hill-Burton hospital construction program two years beyond its scheduled expiration date of July 1, 1957. This also has passed the Senate, has cleared the House committee, and is only a few steps from enactment.

A long list of less important health measures also shares the same uncertain status: grants to promote mental health work, a national survey of sickness, a new mental health program for Alaska, and a national library of medicine.

On the three major bills, here are some developments and prospects:

U.S. CIVILIAN EMPLOYES

Earlier in the year the administration dropped the idea of basic coverage for its employes (White House objection to payroll deductions), and offered instead a free major medical expense indemnity policy. While unions representing the workers directly affected supported the plan, it was pretty well stamped into the ground by the American Hospital Association, Blue Cross and Blue Shield, and the top officialdom of AFL-CIO.

But the Civil Service Commission and legislators interested in the plan did not give up. They worked out a device that they hoped would dilute the opposition; they proposed that, in addition, a system of basic hospitalization insurance be set up under the payroll deduction plan—provided the U.S. comptroller general found that payroll deductions would be feasible.

This tentative offer of basic coverage appeared to mollify the American Hospital Association to some degree, but to Blue Cross and Blue Shield it didn't look any better than the earlier bill. At this writing the labor witnesses have not testified. When they do, it is possible they will split, with the government unions accepting the bill and the national organizations opposing it.

A.H.A. did not embrace the bill, nor did it oppose major medical coverage as such. Its position was that major medical coverage, to be effective, has to be tied in with basic coverage. Dr. Dwight Barnett of Columbia, A.H.A.'s witness before the House committee, argued that a service plan was preferable to an indemnity plan. "Indemnity insurance leaves the insured with a part of the bills to be paid from his own pocket," he said, "and too often that part turns out to be larger than he anticipated. . . . Indemnity . . . can take no responsibility for controlling the cost of service."

Dr. Barnett then went on to point a finger at the private practice physicians, stating: "Whatever fraction of the charges the [indemnity] insurance fails to cover is apt to be difficult to collect, with the result that those providers with standardized rates must absorb the loss, and those who are free to do so are tempted to adjust their charges upward."

In conclusion he declared: "Major medical insurance is a desirable adjunct, if the government is prepared to assume or share in the added expense, but only to the extent of rounding out the protection against those exceptionally heavy costs that basic programs are not yet in a position to meet."

There is no question at all about how Blue Cross and Blue Shield stand. Their representatives denounced the new plan with the same enthusiasm they showed in pouncing on the old one.

As of this writing, there is a slight chance that Congress will ram through the bill, despite all the criticism, and promise to attempt to work out basic coverage at a later date.

"LITTLE OMNIBUS BILL"

The "Little Omnibus Health Bill" was worked up late in the session on the Senate side. It is a five-point program providing, in addition to extension of Hill-Burton, trainee grants for physicians and other public health personnel, for the graduate training of professional nurses, for practical nurse education, and for experimentation and training in mental health.

This is perhaps the only opportunity for the Hill-Burton extension to slide through this session and avoid the Powell antisegregation amendment. There is no opposition of consequence to continuing the H-B program, but there is a reluctance to expose it to the Powell amendment, which would mean death of the bill in the Senate.

The Powell amendment also is a factor in progress of the bill for U.S. grants to help in constructing medical research facilities. If this obstacle is removed — possibly through beating down the antisegregation forces in a direct vote on the school aid bill—the research bill would be enacted without too much trouble.

LESSER HEALTH BILLS

Of the less important health-medical bills, that authorizing a Public Health Service survey of sickness is most likely to be enacted. The survey would be a continuing operation, and would look into all statistical aspects of illness, including days of hospitalization and type and extent of medical care furnished.

The movement to make the Armed Forces Medical Library into a National Library of Medicine, long in developing, ran into trouble from an unexpected source. After the military services, the U.S. Public Health Service, and all the professional associations came to an agreement on the change, Illinois senators and representatives moved into the picture. They demanded that the new library be located in Chicago, not in Washington as specified by the bill.

They were able to stall the bill, after it had passed the Senate and received preliminary approval from a House committee. The chances were about 50-50 that the plan would fail altogether. Congress, reluctant to turn down the big Illinois delegation flatly, was still more reluctant to locate the institution in Chicago.

NOTE: In the Senate, the American Hospital Association scored a point. It had the bill changed to include on the library's board a representative from the field of hospital administration.

As Congress moved within weeks of adjournment, the bill to commission osteopaths in the military medical services was badly muddled. It had passed both Houses, but there was still an unresolved conflict over it in the Defense Department itself: Dr. Frank Barry, chief civilian adviser to the department on medical matters, favored the bill, while the three military surgeons general opposed it. Conference action was required on the bill, and there was a good chance that it would not become law.

HILL-BURTON APPROPRIATION

While conferees were slow in getting to the measure that contains Hill-Burton appropriations for this fiscal year, the Senate made certain that the final decision would not be too unfavorable.

Statistically, this is the situation: The President asked $130 million for the entire program. In the House, $19 million was cut from the appropriations for the new part of the program—clinics, health centers, nursing homes, chronic disease hospitals. The Senate took another tack; it restored the $19 million, but earmarked it for the regular program.

The conference committee decided on a total of $125 million, divided this way:

$102 million for regular Hill-Burton.

$1.2 million for research.

$21 million for the new program.

In the Senate the money bill also was amended to solve one problem that has plagued H-B from the beginning. Its appropriations bills have required that the money appropriated be allocated within two years or revert to the treasury. Through the efforts of Senator Hill, this was changed so that future H-B appropriations bills will make the money available "until expended." Because the provision is not in the current appropriation for the new part of the program, about $3 million probably will have to be returned to the treasury.

FEDERAL RESEARCH INCREASED

In the health field, the most amazing fact about this Congress is that it stalled, debated and procrastinated on a score of inexpensive health bills—but at the same time freely agreed to increase federal research spending by at least 50 per cent. The exact percentage increase depends on conference committee action, but it is certain to be the highest in history.

Several of the seven research institutes, in fact, are likely to receive increases of close to 100 per cent over current spending. For example, the Senate wants the cancer institute's spending to move up from $24 million to $48 million and the mental health program from $18 million to $35 million.

So abrupt are the increases that one of the problems will be to find qualified researchers and assistants to carry out the projects. For several years now the Department of Health, Education and Welfare has been warning Congress that research will be stalled unless federal money is spent to train researchers. Now, there is the possibility that the traineeships won't be authorized (part of "Little Omnibus Bill" already discussed), but that nevertheless more money will be voted for research.

NOTES

Chairman Percy Priest's health subcommittee in the House has held hearings on Rep. Frances Bolton's bill for a federal nursing commission. Then the full committee voted not to report it to the floor. As expected, the American Medical Association favored the idea, the nursing associations opposed it, and the American Hospital Association steered a middle course. While not opposing the idea of a study of nursing problems, the A.H.A. opposed the particular bill. It suggested instead that a three-year study be made by a nonfederal group.

The Modern Hospital
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ACCREDITATION GETS "A" FROM A.M.A.

House of Delegates supports Joint Commission but asks for changes in standards and procedures; "corporate practice" by medical schools condemned

Chicago.—Hospital accreditation is here to stay, in the opinion of the only group that might have let it go—the House of Delegates of the American Medical Association.

Without a dissenting vote and with only one change aimed at protecting the position of general practitioners on hospital staffs, the house—in session here during the A.M.A.'s 105th annual meeting—adopted the report of the special committee appointed a year ago to review the functions of the Joint Commission on Accreditation of Hospitals. The committee was headed by Dr. Wendell C. Stover, 45 year old general practitioner from Boonville, Ind., who was one of the outspoken critics of the Joint Commission last year.

In its report to the house, the Stover Committee said flatly that accreditation should be continued and the Joint Commission should maintain its present organizational representation.

As a result of its year-long investigation of the commission, the committee concluded that dissatisfaction with the functions of the Joint Commission is not as widespread as committee members had been led to believe. "It is also evident that much of the criticism is based on misunderstanding and misinformation," the report said.

In its conclusions and recommendations, however, the Stover Committee urged a number of changes in Joint Commission procedures and standards. Among them:

1. Compulsory attendance at hospital staff meetings should be eliminated as a standard, and attendance requirements should be set up locally by individual hospitals.

2. Commission surveyors should be directly employed and supervised by the Joint Commission, instead of by its constituent organizations.

3. Survey reports should be submitted to the chief of staff as well as the administrator of the hospital, and surveyors should work with staff representatives as well as the administrator while surveys are being made.

4. The Joint Commission should encourage medical staff representation on hospital governing boards, with or without voting power.

5. The commission should give serious consideration to establishing standards which may vary depending upon the size of the hospital.

6. The commission should concern itself with questions relating to illegal or unethical contracts between hospitals and physicians.

After receiving printed copies of the report in advance of the meeting, delegates listened attentively as Dr. Stover presented an illustrated talk explaining the structure and operations of the Joint Commission and briefing the committee's recommendations. The report was received without comment, except for a burst of applause for the recommendation to eliminate compulsory attendance at staff meetings. The report was then referred to the Reference Committee on Medical Education and Hospitals for discussion.

Prodded by Dr. John S. DeTar, president of the American Academy of General Practice, the reference committee added a single recommendation urging the commission to study "problems of the exclusion from hospitals and arbitrary limitation of the hospital privileges of the general practitioner," and to seek methods whereby hospital privileges can be determined and granted "on the basis of professional qualifications and demonstrated ability."

Dr. DeTar's suggestion came near the end of an hour's discussion of accreditation at the reference committee meeting, which was attended by some 200 A.M.A. delegates and members. Earlier, members of the Stover Committee and Dr. Kenneth B. Babcock, commission director, answered a number of detailed questions about commission standards and procedures.

In response to a question from Dr.

A.M.A. ELECTS ALLMAN

Chicago.—Dr. David B. Allman of Atlantic City, N.J., was named president-elect of the American Medical Association at the annual meeting. Dr. Allman has been a member of the association's board of trustees, and a member of the Council on Medical Service. A graduate of Jefferson Medical College, Philadelphia, he is a Fellow of the American College of Surgeons and is chief surgeon and director of the department of surgery at the Atlantic City Hospital.

DR. HESS

DR. MURRAY

DR. ALLMAN

DR. BABCOCK

George S. Klump of Williamsport, Pa., reference committee chairman, Dr. Stover said he was satisfied the committee's report answered all the questions raised about accreditation in critical resolutions presented to the A.M.A. last year, and two additional resolutions introduced at this session.

Elaborating on a question raised in one of the new resolutions, Dr. Babcock said it was his intention to recommend that the commission discontinue publication of the list of provisionally accredited hospitals. Instead, he said, one list would be published, including accredited and provisionally accredited hospitals in the same classification. The provisionally accredited hospital would thus have a "probationary year" to correct deficiencies without having its loss of full accreditation status publicized, Dr. Babcock explained.

Another resolution introduced this year proposed separate standards for small hospitals. The commission opposed any such move, Dr. Babcock said. "Our procedures should certainly be fair and flexible as we evaluate hospitals," he said, "but the Joint Commission feels it is wrong to classify hospitals and set up any double or triple standards. The quality of medical care should be the same in all hospitals."

This position was supported by the reference committee in its report to the house. "The committee recommends that no action be taken on the resolution but wishes to emphasize the importance of flexibility in judgment in the application of any set of standards to a particular local situation," the report said.

While one or two speakers were critical of hospitals, the reference committee discussion was notably free of the bitter antagonism toward hospital boards and administrators that has characterized discussions of accreditation and related problems at other recent A.M.A. meetings—a circumstance that some observers attributed to the generally favorable content of the Stover report.

Suggests "Brainwashing" Trustees

Commenting on a committee recommendation that the A.M.A. and American Hospital Association should encourage educational meetings for hospital trustees and administrators to acquaint them with the functions of accreditation, a delegate from Massachusetts enlivened the hearings with a suggestion for "brainwashing" trustees in their hospital duties and responsibilities. Too many trustees are influenced by small groups of doctors, ignoring the problems of the staff as a whole, he charged. "Few trustees know what is actually going on. The Joint Commission should brainwash trustees as to their duties in the hospital," he said, to an accompaniment of embarrassed tittering from an audience that couldn't quite tell whether he was serious or not.

Doctors themselves are responsible for loss of control over medical matters where this has happened, Dr. L. Howard Schriver of Cincinnati, who has been one of the severest critics of hospitals and the Joint Commission in past years, acknowledged during the discussion. "Hospitals are an ever greater part of medicine," Dr. Schriver said. "We demand this for our own convenience and efficiency. Where hospital adminis-

A.M.A. President Says Hospital-Physician Relations Have Gone From Bad to Worse

CHICAGO.—Hospital-physician relations have gone from bad to worse during the last year, Dr. Elmer Hess of Erie, Pa., retiring president of the American Medical Association, said in his farewell address to the A.M.A. House of Delegates here last month.

Referring to hospital-physician litigation in Iowa, Ohio and elsewhere, Dr. Hess said, "Lawsuits and threatened lawsuits seem to be the order of the day. In my opinion, no matter who wins in such litigation, each group has damaged itself in the public's opinion.

"The reason for this is simple. The public doesn't understand what the controversy is all about. It takes good faith on both sides with reasonable men of good will to sit down around a table and solve the physician-hospital differences. This should preferably be done at the local level, and I know that all the controversies can be adjudicated under our code of ethics."

A man of resolute belief in the magic of the conference table, Dr. Hess also referred to joint conferences of A.M.A. and American Hospital Association trustees. "This is a two-way road, and if we do not resolve our differences both groups will lose their identities and be swallowed by government," he said. "These high level consultations must continue and eventually produce results if we are to stay out of the courts and prevent legislation that is only damaging to both groups and to the public."

Conference tables everywhere will have to produce results at high speed to avoid the legislative troubles Dr. Hess foresees. Labor is about to launch an all-out drive for national compulsory health insurance, he reported, quoting from recent speeches by George Meany, AFL-CIO president, and Nelson Cruikshank, head of the AFL-CIO social security department.

"It is my personal belief that some of these leaders in the labor movement might be more interested in destroying the two-party political system than they are in protecting the rights of citizens they are supposed to represent," Dr. Hess declared.

Hopefully, Dr. Hess reported, some union leaders, and rank and file union members, have shown they will have no part of national compulsory health insurance. "As long as we can continue to produce good medical care at reasonable cost," he concluded, "as long as we respect the workers' rights to their own fields of organization, I think we will continue to have millions of friends in the ranks of labor regardless of what some of their leaders may try to do. Physicians and labor, working together realistically, can bring better medical care to all of the people."

trators have run off with the ball, the great fault has been with us. We have never asserted ourselves in management."

Doctors always fear bureaucracy, Dr. Schriver stated. Nevertheless, he acknowledged, the Joint Commission must have some regulatory powers in order to function effectively, and the line between freedom and regulation is always indefinite.

"As long as we have men of Dr. Babcock's character in command, we can feel secure in the protection of our individual freedom and dignity," he concluded, adding that the Stover Committee had done a magnificent job and laid to rest many of the doctors' fears about accreditation.

This view was shared by the reference committee, which congratulated the Stover Committee for the "painstaking work and great ability indicated by its clear and concise conclusions."

Delegates Praise Committee

While there were one or two delegates who grumbled privately that the Stover report was a "whitewash," this view was never expressed openly, and the general feeling among the delegates, obviously, was in agreement with the reference committee's conclusion that the Stover Committee had "performed a very difficult task superbly, that its conclusions are in the public interest, and their implementation will result in the best possible medical care of the patient."

Following presentation of his reference committee's report, Dr. Klump reminded delegates that their approval of the Stover Committee recommendations did not constitute a mandate to the Joint Commission, and that implementation of the recommendations would require consideration and approval by members of the commission. In the general atmosphere of congratulation and hallelujah that prevailed at the moment, however, this reminder went largely unnoticed, and many delegates, unquestionably, started homeward happily, thinking they would be excused henceforward from attendance at hospital staff meetings, if not elected forthwith to membership on the board of trustees.

The committee recommendation urging the commission to concern itself with questions of illegal or unethical contracts between hospitals and physicians went unnoticed and undiscussed, but it also offered possible complications for the future. Explaining it, the Stover report said, "In the opinion of the committee, the existence of such practices must be determined at local level because the laws of the several states are not uniform. The effect of particular questioned practices should best be discussed by the field representative, the chief of staff, and the administrator at the joint meeting of these parties recommended [in the report]."

In another important action, the House of Delegates took a militant stand against "corporate practice" by medical schools. Considering a detailed report on private practice by medical school faculty members prepared during the last year by the Council on Medical Service, the house voted down a resolution to defer action for six months and adopted the report, by a 2 to 1 majority, making it A.M.A. policy that "funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution, and the initial disposition of

Patients Want the Truth, Dr. Murray Tells A.M.A.; Warns Against Growing GP-Specialist Tension

CHICAGO.—Patients want to know the truth about their illnesses, and doctors should present the facts frankly and honestly, Dr. Dwight H. Murray of Napa, Calif., newly elected president of the American Medical Association, said in an address to the A.M.A. House of Delegates at the annual meeting here last month.

Dr. Murray succeeded Dr. Elmer Hess of Erie, Pa., as A.M.A. president during this 105th annual meeting.

Lack of frankness and honesty in explaining diagnoses, treatment and surgery performed is a frequent complaint of patients about doctors today, Dr. Murray told the delegates. "The desire to know what's going on has become a part of the make-up of most Americans," he said. "So when a doctor tells his patient, 'Don't worry about a thing,' he is not fostering good doctor-patient relationships. Why should a patient accept such a vague statement? His health is his personal concern, and he should know if he has a disease or if he doesn't—if he needs an operation or if he doesn't.

"There are extreme cases, of course, when the full story cannot be told to the patient. But in these cases, a relative or close friend should be informed. In almost all cases the patient has a right to know. He has the right to know what we have discovered about him—whether it is good news or bad news."

Speaking as a general practitioner, Dr. Murray referred to action by the A.M.A. last year aimed at obtaining hospital privileges for the general practitioner "in keeping with his merits and demonstrated ability."

"I am convinced there is not a general practitioner in the country," Dr. Murray said optimistically, "who would not agree that the phrase 'in keeping with his merits and demonstrated ability' is by far the most important part of this resolution. General practitioners throughout the country want no special privileges, but only the right to make available to their patients all the modern advances of medical science without discriminatory restrictions unrelated to professional attainment."

Warning against what he sees as growing tension between general practice and the specialties, Dr. Murray said a similar division speeded the advent of socialized medicine in England in 1947. "Restrictions, special privileges and favoritism have virtually divided the medical profession in England," he warned. "It can happen here, unless we begin to think in terms of the medical profession as a whole and our responsibilities to the American people, rather than perpetuating our petty jealousies."

In his inaugural address as president of the association, Dr. Murray emphasized the need for medical teamwork:

"No particular type of physician—whether he be a general practitioner, a surgeon or a medical specialist—should be considered the golden boy, the all-American, entitled to a lion's share of prestige and reward," he said. "Modern medical care is a complex service requiring the coordinated efforts of family doctors, all kinds of specialists, chemists, pharmacists, researchers, laboratory and x-ray technicians, nurses, dietitians and many other groups of auxiliary personnel."

A.M.A. Acts on Internships, Ethics, V.A., Isotopes, Education, Emergency Service

IN ADDITION to its consideration of accreditation, medical school practice, and foreign medical graduates, the A.M.A. House of Delegates also acted on a number of other reports and resolutions of interest to hospitals. Briefly, the House of Delegates:

1. Requested the Council on Medical Education and Hospitals to "increase its efforts to encourage rotating internships rather than straight internships in all hospitals approved for the latter," but turned a deaf ear to the plea of obstetricians and gynecologists that all straight internships be abolished right away, or that the straight internship in obstetrics and gynecology be reinstated to approved status.

2. Listened politely as two delegates explained how the "one-fourth rule" on internships worked a hardship on some small hospitals, then turned down a resolution requesting that the one-fourth rule be rescinded.

3. Tentatively approved a sweeping revision of the Principles of Medical Ethics that would separate ethics from etiquette and reduce the Principles to a few simple statements, but postponed final action on the revision for another six months.

4. Heard impassioned delegates from Texas and California declare the A.M.A.'s position favoring federal grants for medical school construction would lead to socialism, riot and ruin. The house applauded the speakers heartily, then calmly voted down a resolution opposing such grants.

5. Asked the U.S. Government to return the general wholesale and retail purchase of Salk anti-poliomyelitis vaccine to normal commercial channels and "cease governmental purchase of the vaccine in other than those amounts needed by the Public Health Service for essential public health needs and distribution to the indigent population."

6. Referred to its Committee on Legislation a Texas resolution asking the A.M.A. to recommend legislation providing an "accelerated tax write-off" for costs of new construction or expansion of hospitals owned by private physicians or groups of physicians.

7. Praised the A.M.A. Council on National Defense for its work with state medical societies and other agencies in disaster preparedness and emergency medical services, and urged the council to "complete its plan for an organization by which the medical profession can be mobilized to meet the current and future need for an adequate national medical civil defense program."

8. After protracted debate on a resolution to rescind an A.M.A. policy recommending that the use of radium and radioactive isotopes be under the supervision of one certified in radiology or therapeutic radiology, refused to act either for or against the resolution, and, instead, requested the Speaker to appoint a committee to study the use of radioactive isotopes and report to the board of trustees before the next meeting.

9. Noted that care of veterans with nonservice-connected disabilities in V.A. hospitals is a "continuing threat to the proper and private practice of medicine," and requested the board of trustees to continue efforts to control this abuse.

10. Urged state and county medical societies to cooperate with the Defense Department in the provision of medical care for servicemen's dependents as provided in Public Law 569, utilizing such insurance, medical service or health plans as permitted by the law, provided the plans are approved by the local county or state medical society.

fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

The motion to delay action on the report for six months produced one of the liveliest debates, and the worst parliamentary snarl, the A.M.A. house has seen in recent years. At one point, proposals to approve, amend, delay, postpone, refer and re-refer the report piled up so alarmingly that when a delegate asked in some bewilderment what he would accomplish by voting "yes" on a motion under consideration, Speaker Vincent Askey of California replied quickly, "You'd get the Speaker out of a dilemma!"

Eventually, a motion to re-refer the report to the Reference Committee on Insurance and Medical Service prevailed, giving delegates another 24 hours to study the report, which some members claimed they had not had an opportunity to read.

When the house reconvened, in spite of warnings that action now might cause a rift between teachers and practitioners of medicine, it was plain the majority wanted to go on record right away in opposition to private practice as it is carried on in many medical schools today, with fees collected and retained by the universities.

"It is the council's belief that a nucleus of full-time clinical faculty members in the medical school is necessary," the report said. "The council believes that as a general rule the full-time clinical faculty members should *not* be permitted private practice but should be paid an adequate salary by the medical school. Exceptions because of legal or local conditions may be necessary.

"However, the council believes it is a primary responsibility of the administrators of medical schools to exercise adequate controls over the extent of private practice, so as to maintain a proper relationship between teaching responsibilities and private practice.

"The council believes that charges should be made, where possible under the existing laws of the state, to the physician for all facilities and personnel involved in his private practice, prorated in accord with the use of such facilities in his private practice."

The report also suggested establishment of liaison committees between medical schools and state medical associations, and recommended that "all patients treated in medical school facili-

(*Continued on Page* 144)

Failures Offer Clues to Success

Since it is virtually impossible to pin down the qualities that make an effective administrator effective, the author takes a reverse approach and analyzes the qualities that make an ineffective administrator ineffective

RAY E. BROWN

EFFECTIVE administration has proved to be a most necessary element of the highly developed and complex environment which we moderns have created for ourselves. A jet-stream of scientific and technological advances in every direction has opened the way for a more productive, more leisurely, and healthier life. These same advances, however, have so enormously complicated our efforts toward this more abundant life that we have had to organize our means and our efforts for work, for play, for health, and even for worship. This need for planning and direction has created a multiplying need for competent administrators to manage all those activities in which we work, or which work to serve us.

The growing demand for competent administrators has created a man-hunt of immense scope on the part of the countless firms, agencies and institutions that make up our economy and our society. Naturally, a man-hunt calls for a description of the party being sought. In recent years considerable effort has been devoted to the problem of describing the characteristics of the effective administrator. Successful administrators have been cross-sectioned at work, at home, and at play in an effort to ascertain the common traits possessed by those who have demonstrated competence.

As one reviews these efforts he is impressed with the similarity of the list of characteristics of the effective administrator and those usually ascribed to the average good citizen. Certainly, the effective administrator must be honest and loyal, possess integrity and enthusiasm, and love his fellow man if he is going to be allowed to run loose in society and not be avoided by his own secretary. It is doubtful, however, that he can parlay those virtues alone into a successful career as an administrator. Possession of the proper traits and skills is not in itself sufficient. It is their appropriate use by the administrator that determines the degree of administrative success. From the same piece of steel one may fashion a lock or a burglar's tool for breaking the lock.

Administration simply cannot be judged by the segmental attributes of the administrator but rather by his total actions and reactions. Administration is practiced in situations and is also the practice of creating situations. It is what the administrator does, or does not do, that produces an effect on the organization. In other words, it is administrative behavior that determines the sorts of influences the administrator will have on the organization.

An attempt to define proper administrative behavior requires the inclusion of so many elements of ordinary good behavior that one ends up in pretty much the situation of those who have attempted to describe the traits the good administrator must possess. For this reason I felt that new and useful information regarding the effective administrator might be gained if we reversed the usual approach and examined some of the behavioral characteristics of the ineffective administrator.

The following generalizations represent such an attempt. These generalizations are compiled in part from discussions with persons who have experienced marked failure in administration and also with persons who have experienced marked success in administration.

Those discussions were necessarily of a leading and directive character inasmuch as one cannot expect individuals to demonstrate much more insight in reviewing their experiences than was demonstrated when they were undergoing them. Also, as one might suspect, a considerable portion of the observations represents reflections on my own conduct as an administrator. Actually, the characteristics observed are very human ones and perhaps are never completely eliminated. Successful administration seems dependent, however, on successfully modifying

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Adapted from a paper presented at the Association of Western Hospitals, Seattle, and other regional hospital meetings. Mr. Brown is president of the American Hospital Association and superintendent, University of Chicago Clinics.

"Sidestepping an issue is just as bad as stiff-arming it"

their inhibiting effect on administrative behavior.

1. All or Nothing at All Complex

One of the commonest characteristics of ineffective administration is the tendency to attempt only perfect solutions instead of those that can be accomplished. This can be described as the all or none complex. Administratively this all or none complex leads to two extremes—both of which are harmful to the organization. On the one extreme it may mean that improvements are never undertaken because the ideal solution isn't currently available or possible. Necessary changes are never accomplished because the opportunity for perfect solution rarely comes along. Major changes are always difficult to accomplish and even the bravest and most energetic of administrators are sometimes tempted to rationalize their distaste for facing up to those difficulties by waiting for the perfect solution.

On the other extreme it may mean that the action undertaken is too radical and the organization is subjected to turmoil and violent upheaval. Under these circumstances the changes attempted may be ultimately correct but currently just not possible of accomplishment. Such moves ignore the necessity for administrative timing. The successful administrator must on occasions tolerate conditions of inefficiency rather than court failure by attempting to clear all the obstacles with one great push. He must determine his goals and evaluate the opposition to them. This permits him to maintain constant pressure toward the desired ends without allowing the pressure to explode into an open break. It also makes him willing to accept and attempt alternatives if they move toward the ultimate objective.

Among his repertory of virtues the effective administrator needs a high frustration level. Somewhere between the extremes of procrastination and those of abortive change the effective administrator finds the path of consistent progress. By proceeding along that path, step by step, the administrator can ultimately achieve his long-range plans and at the same time ensure the personal stimulation, so necessary to his own morale, that derives from immediate accomplishments. It will help the administrator if he keeps constantly in mind the fact that apparently ideal solutions are themselves only estimates at a given time, and are subject to the many errors inherent in predicting results of human activity. In this sense all solutions are only proximate ideals and never absolute ideals.

2. Urge to Act From Expediency

Before someone interprets the foregoing as an argument that the good administrator is afraid of his own shadow I must point out an opposite characteristic that is equally conducive to ineffective administration. This is the urge to act from expediency—the attempt to buy our way out of problems by yielding to immediate pressures and ignoring the long-run effects of the solution. Sidestepping an important issue is just as bad as stiff-arming it. In some ways it may be worse because it permanently weakens the administrator's influence in the organization.

Yielding to the pressures of the moment is an open invitation for a raid by the most aggressive and most vocal members of the organization. It is a sort of cafeteria administration in which everyone strong enough picks out his own policies. It is properly interpreted by other members of the organization as evidence of indecision and uncertainty and, organizationally speaking, the only thing worse than a bad decision is indecision. It demonstrates a lack of convictions as to long-run goals or else an unwillingness to stand up and be counted on issues important to the welfare of the organization. Either situation results in administration by default. A policy of peace at any price has seldom produced peace but has always raised the price.

In this connection it should be pointed out that administration is not a popularity contest and that many administrative decisions represent choices between opposing views within the organization. This is particularly true in hospital administration because of the diversity of interests represented, when measured in the short run. While all groups, externally and internally involved, may have the same long-term purposes their daily interests are not so clear and unified. Under such circumstances it isn't possible to have all sides like all decisions, but it is possible and important that they respect them.

The failure or inability to weigh the implications to the organization of decisions based on expediency may produce two unfavorable results. As in all cases where the treatment is aimed at the symptoms rather than the cause it may mask the basic cause of the problem and thus prevent the solution when the solution is most easily accomplished. Administration is not a game of solitaire that can ignore the rights that individuals develop in precedent and established practices within an organization.

The results of expedient decision may not come to a head until long after strong organizational habits have been developed, and strong claims staked out, on the basis of those decisions. Corrective measures usually take even longer to implement unless upheaval is to result. The trauma to the organization is bound to be greater when circumstances are not corrected and encouraged to grow into situations. Another unfavorable result from decision making on a first-come-first-served basis is the damage to continuity of policy.

Perhaps no requisite is as important to an organization as that of predictability of administrative reaction. It is the only way the administration can influence the hundreds of decisions made at all work levels in even the smallest of organizations. It is tough enough to develop an organization that wants to do what the administration wants done but it is impossible to accomplish the administration's wishes unless those wishes can be predicted. Without consistency in decision making at the top level there is no basis for predicting administrative wishes at other levels in the organization.

Zigzag decision making imposes an intolerable burden on those who have the task of keeping in step with the leader.

3. Obsession to Win Is Handicap

The obsession to win represents another serious handicap to administrators. This is often demonstrated in the attempt to win a "moral victory" even after decisions have been clearly discredited. Too much emphasis is given in administration to the necessity of saving face and not enough thought is given to the problem of saving respect. The administrator may silence, but he cannot fool, those responsible for carrying out an impractical decision. If face saving is really important it would seem better strategy for the administrator to sweep his errors under the carpet as quickly as possible rather than give them the prominence that results from the disgruntlement and ill will of those compelled to operate with them.

As every kid knows, the best thing to do with a lemon is to make lemonade out of it. It is surprising how many improvements in administration have come out of things that went wrong. It is quite possible that we learn more from our failures than our successes. The administrator should consciously develop the ability to lose a point gracefully. In too many instances we not only finally lose the point but we succeed in losing the good will of those involved. The effort to perpetuate an error can sometimes eat heavily on the time and energy of the administrator. But more important is the way it chews on his disposition. This is demonstrated by the feeling of relief, and even pride, one experiences on those occasions when he is big enough to admit he was wrong.

The obsession to win at all costs is the single largest deterrent to full participation by colleagues and subordinates. There can be no battle of ideas within the organization if the reward is disfavor and ill will from the boss. The willingness, and the ability, to permit decisions to be discussed and pulled apart before committing the organization to follow them represents about the only method available for pretesting administrative ideas. The administrator deals in ideas and these, unlike objects and goods, cannot be tested in the model stage before being placed on the market. Permitting colleagues to participate in decision making is not so much a favor to the participants as it is a favor to the administrator. It not only permits pretesting of decisions and ideas by exposing them to the scrutiny of those who will have to use them, but it assures support instead of sabotage. Human nature being what it is, there is no better way to ensure support, as well as defense, than to involve others. To coin a phrase, this represents conspired leadership and such leadership is probably the most adhesive of all.

4. Everything Is Black or White

High among the factors that contribute to ineffective administration is the tendency to classify everything as black or white—as all good or all bad. This fault denies the fact that it is the administrator's task to discriminate between acceptable alternatives more often than between right and wrong. Situations are rarely ever black or white but are usually varying shades of gray. At least, if the administrator is fulfilling his proper function only the gray decisions will reach his desk. The easy ones will be settled down the ladder where the facts are more abundant. Problems which are screened to the top level of the organization usually carry with them the troubled ponderings of those involved along the line of ascent.

Whether the need is for choice between conflicting views or reassurance as to proper direction, questions reaching the top level must be treated with respect. Such respect may dictate an audience with the individual or individuals involved. This not only demonstrates interest and concern on the part of the administrator but reveals both the facts and the feelings that produced the problem. The feelings often give more weight to a problem than do the facts. When a person is disturbed the facts can turn quickly into fancy and the two must be carefully unraveled before a solution will be fully accepted.

The urge to use the black-or-white technic in administration is a strong one and can develop from several directions. The deficit of time which always plagues the administrator doubtless causes him to seek quick answers. The housekeeper instinct to get things settled and the file off the desk can lead to quick off-the-cuff decision. In other instances emotional factors can cause the administrator to pick sides and thus eliminate the bother of looking at the other side. The proven advantage of decisiveness in administration may also be a strong factor. The urge to simplify problems can of course represent an important asset of the administrator if it is tempered with the knowledge that the etiology of most management problems is multifactorial and multi-sided.

5. No Sense of Proportion

Somewhat related to the all-or-none complex is the failure to maintain a sense of proportion—a sense of balance in administration. This fault manifests itself in several ways in administrative behavior. One of these is best described by the old expression "making a mountain out of a mole-hill." It results in overemphasizing incidents and problems that have little consequence to the organization. It not only wastes the energies and attention of the administrator but it diminishes the influence of the administrator on matters that are important. Subordinates easily develop organizational calluses for this reason and both the whip and the sugar should be given only when circumstances warrant. The fault is also exhibited by administrators who are unhappy unless they skin an elephant every day. They find it difficult properly to distribute their enthusiasm and energies and have interest only for the big projects and the big deals. Even the interest in the big deal isn't sustained and it also soon suffers from inattention.

The demands on the time and the energies of the hospital administrator make it mandatory that he learn to put first things first. Administration is

always a matter of selective attention —of recognizing the significant. This is so important that every administrator should preview his activities each day and allocate his time and interests to those problems and matters with highest priority. If he does not do this he cannot avoid practicing administration at random instead of by plan. This means the administrator's attention is devoted to the problems of the more verbose and forward members of the organization rather than to the problems that are really important and timely. It also means that the administrator is unable to delegate responsibility properly because he never knows what to delegate. It demonstrates he is able to carry a load but not smart enough to share it. The insecurity that is bound to result from failure to exercise selective attention may be the reason that some of us never quit worrying—even about problems that have already been solved or that never even existed.

6. *Failure to Remain Impersonal*

The failure to maintain an impersonal status in the organization can prove to be a serious handicap to the administrator. He must maintain a sufficient degree of aloofness to permit administrative action without its being taken personally. Admittedly, he must be responsive and friendly so that his colleagues will not hesitate to approach him. But he must recognize the difference between liking his associates and liking everything they do. Personal relationships that inhibit detached evaluation and frank criticism represent a disservice to all concerned.

Criticism is fundamental to improvement and every member of the organization has a right to expect that he will be told when his performance needs improvement. Nothing shakes the morale of an organization as much as the suddenly letting down of the boom on an individual without prior effort to correct his deficiencies. The rules of fair play are applied more strictly to the administrator than to anyone else and these rules require that a person be told where he stands and why.

The necessity for fair criticism might seem at variance with the "sweetness and light" doctrine one hears preached so often today. If that doctrine means the administrator has no right to show and express irritation it is indeed at variance with proper administrative conduct. Just as the administrator should demonstrate approval for a job well done so should he demonstrate disapproval for faulty performance. It's the only way the organization can determine the level of performance expected by the administration. The important thing is that the administrator be able to demonstrate irritation without demonstrating hostility and without creating antagonisms. Only by reserving a margin of impersonal relationship can he hope to appear emotionally casual as he carries out his daily task of modifying human conduct.

7. *People Expected to Be Logical*

This matter of human conduct brings us to another cause of ineffective administration. This is the mistaken assumption that people act logically. Individuals do not usually act either logically or illogically when they are personally involved. In such instances they are most likely to act *non*-logically. This is because they are persons and bring to every situation their own personal experiences, biases, desires and needs. Situations are seen from each individual's own uniquely personal perspective. This requires that the administrator must at times temper his decisions to allow for the personal equation and to work toward the modification of preconceived notions regarding those affected by his decisions. The fact that individuals have changing value patterns and motivations, and that these change more rapidly than we think, makes such modification possible. It also requires that the administrator learn to know those with whom he works without stereotyping them. It means that he must realize that his own outlook also is subject to change as he has new experiences. His own reactions have the same tendency to be compatible with his own personal desires. To whatever extent possible, he needs to be cognizant of his personal biases and to allow for these in his evaluations of people and situations. At the same time it is highly important that he maintain respect and confidence in his own judgment. He simply cannot command any more respect from others than he has for himself.

The attempt in this paper has not been to outline all the factors responsible for ineffective administrative behavior. Further study would doubtless bring out equally important causes. Rather it has been an attempt to emphasize the importance of behavior as contrasted with segmentized skills and traits. Administration requires many various skills and knowledges but they are effective only to the extent they are integrated into a balanced practice of administration.

Program Devoted to Patients' Point of View Highlights Upper Midwest Hospital Conference

MINNEAPOLIS.—If patients in the area served by the Upper Midwest Hospital Conference received a little kinder, more understanding care than usual in the days following the Upper Midwest meeting here May 23 to 25, they probably owe it to Sister Agnes Leon of the College of St. Catherine, St. Paul. It was Sister Agnes Leon and her coworkers on the program committee who were responsible for the Thursday morning session, sponsored jointly by the Upper Midwest group and the Minnesota State League for Nursing, and the session was unanimously acclaimed as "terrific."

Nobody slept during this meeting; the delegates were too busy listening to their shortcomings as outlined pathetically, gaily or savagely (according to their temperaments and experiences) by three speakers who had reason to know what they were talking about: patients. The idea of having patients appear on hospital programs has been tired before, but never quite as effectively because few patients have been as outspoken or compelling.

By way of setting the stage for the patient-speakers, Dr. Adelaide Johnson of the psychiatric department of the Mayo Clinic exhorted her audience to try to understand what the patients are thinking and feeling—particularly feel-

(*Continued on Page* 158)

Upper Midwest officers, left to right: Byron Jackson, retiring president; Sister Rose Marie, incoming president; Donald W. Cordes, president-elect.

Power plant smokestack rising behind medical school and hospital.

THE MODERN HOSPITAL OF THE MONTH

School and Hospital Are Under One Roof

The most economical plan was the most functional

DAVID B. WILSON, M.D.

IN MAY 1950 the Mississippi legislature authorized the construction of a four-year school of medicine and a teaching hospital to be known as the University Hospital. Both were to be fully accredited. They were to be integral units of the University of Mississippi.

The Mississippi legislature specifically provided that the University Hospital (1) must be a teaching hospital, (2) must have a minimum of 350 beds, and (3) must at all times have a minimum of 50 per cent of its beds available for charity or service patients. The sum of $9 million was assured for the construction of both hospital and medical school as follows: state of Mississippi, $4½ million; Hill-Burton program, $3 million; county of Hinds, $1½ million.

Before actual planning of the building began, the Korean incident caused a definite increase in construction costs. Without any additional funds in sight it was necessary for the architects to be extremely careful in their planning since by law a minimum of 350 beds had to be provided in the hospital.

Early consideration of the problem demonstrated that the most economical building could also be the most functional. It meant a single building with both medical school and hospital under one roof and with floor area integrated one into the other. Such an arrangement would bring the basic sciences into close relation with the clinical disciplines and with all phases of the hospital.

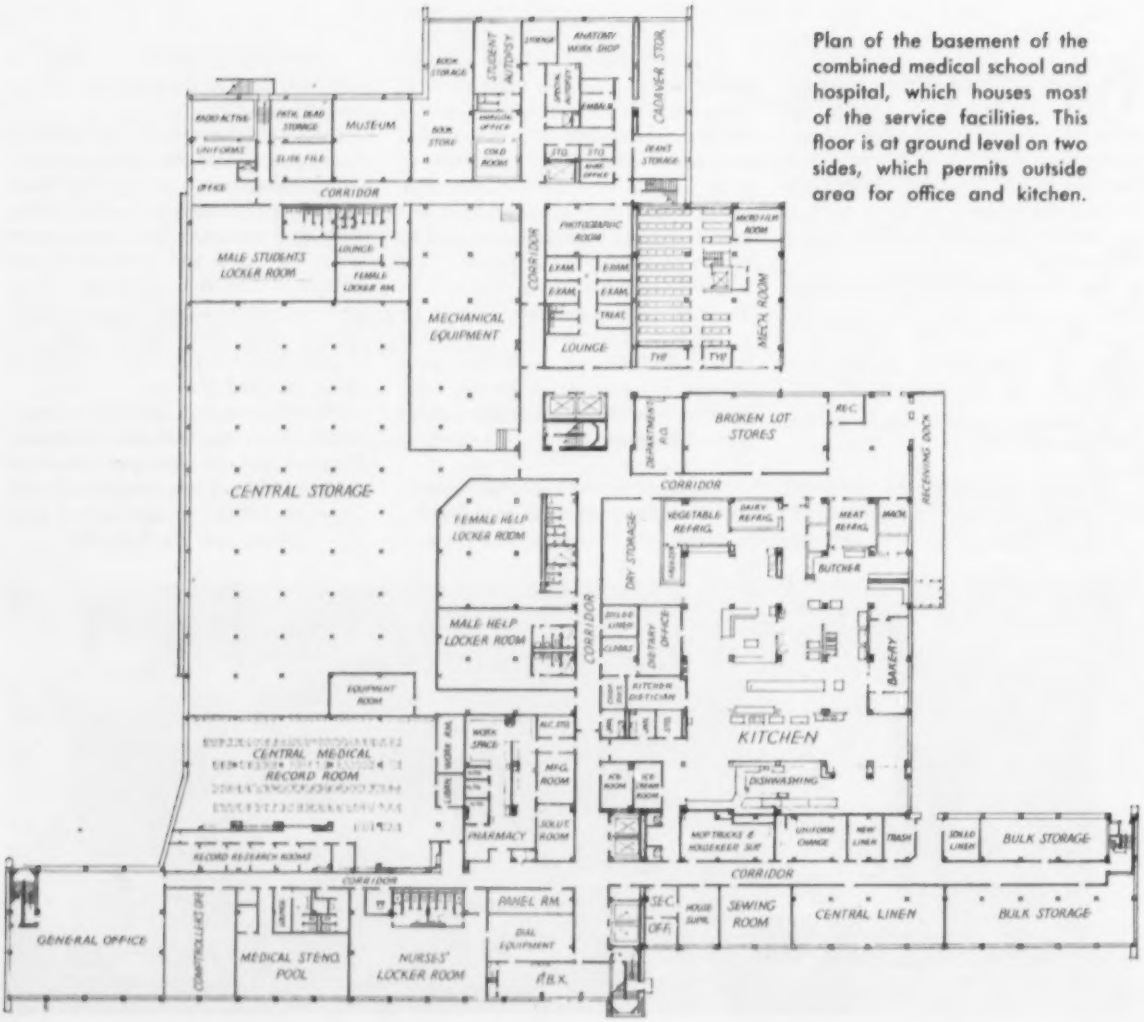
The University Medical Center, consisting of the 350 bed University Hospital and the four-year school of medicine, is a closely integrated building with 463,000 square feet of floor

(*Continued on Page 60*)

Dr. Wilson is director, University Hospital, Jackson, Miss.

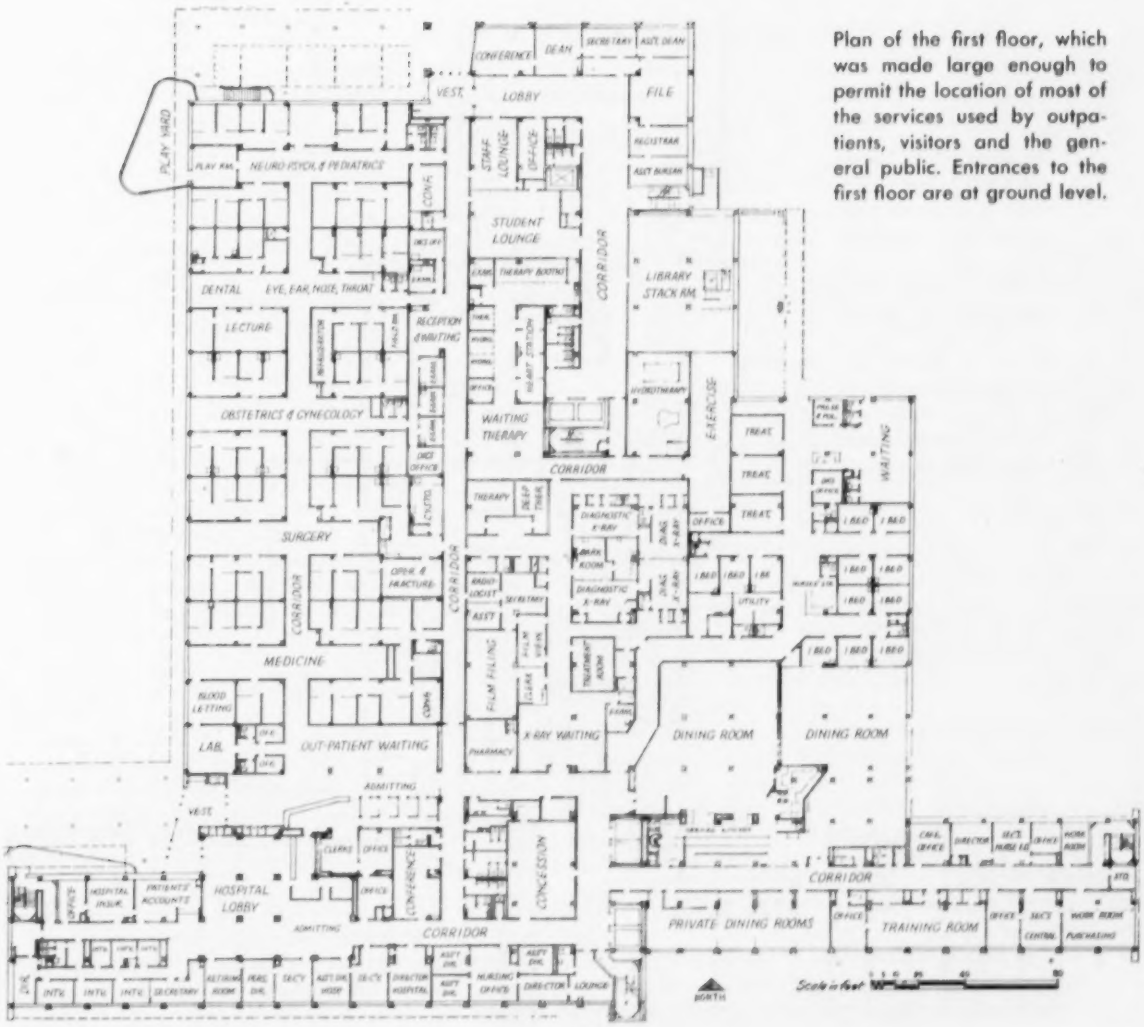
Exterior view from the northwest of the new University of Mississippi Medical School and Teaching Hospital at Jackson. Another façade of the building—from the southwest—is shown on this month's cover.

One of the public waiting rooms in the University of Mississippi Hospital. The floor waiting rooms are painted in bright shades of yellow and dark foliage green, with one red brick wall to produce a pleasant atmosphere.



Plan of the basement of the combined medical school and hospital, which houses most of the service facilities. This floor is at ground level on two sides, which permits outside area for office and kitchen.

The research reading room of the medical library. The decision to make the library multi-story, with stack levels directly under the reading rooms, determined the 15 foot height between ground, first and second floor levels.



Plan of the first floor, which was made large enough to permit the location of most of the services used by outpatients, visitors and the general public. Entrances to the first floor are at ground level.

(*Continued From Page 57*)

area. It is air-conditioned throughout since cooling in Mississippi is usually a bigger problem than heating. The decision to air-condition permitted the planning group to recommend large amounts of inside floor area, which meant that many areas could be located in close proximity to each other without regard to windows and natural ventilation. Such an arrangement also lowered the over-all construction cost.

An early decision provided for a large first floor area to permit the location of most of those services used by outpatients, visitors and the general public at ground level. It was felt that such an arrangement would lessen the need for extensive elevator service since most persons could walk horizontally to various services needed, directly from the outside. All the entrances to the first floor are at ground level with only a curb as the difference in floor and ground or street levels.

Located on the first floor are an outpatient department for 50,000 visits annually, an x-ray department, an extensive emergency and receiving department, physical medicine and rehabilitation, two cafeterias, gift shop and administrative and business areas.

X-RAY SERVICE IN CENTER

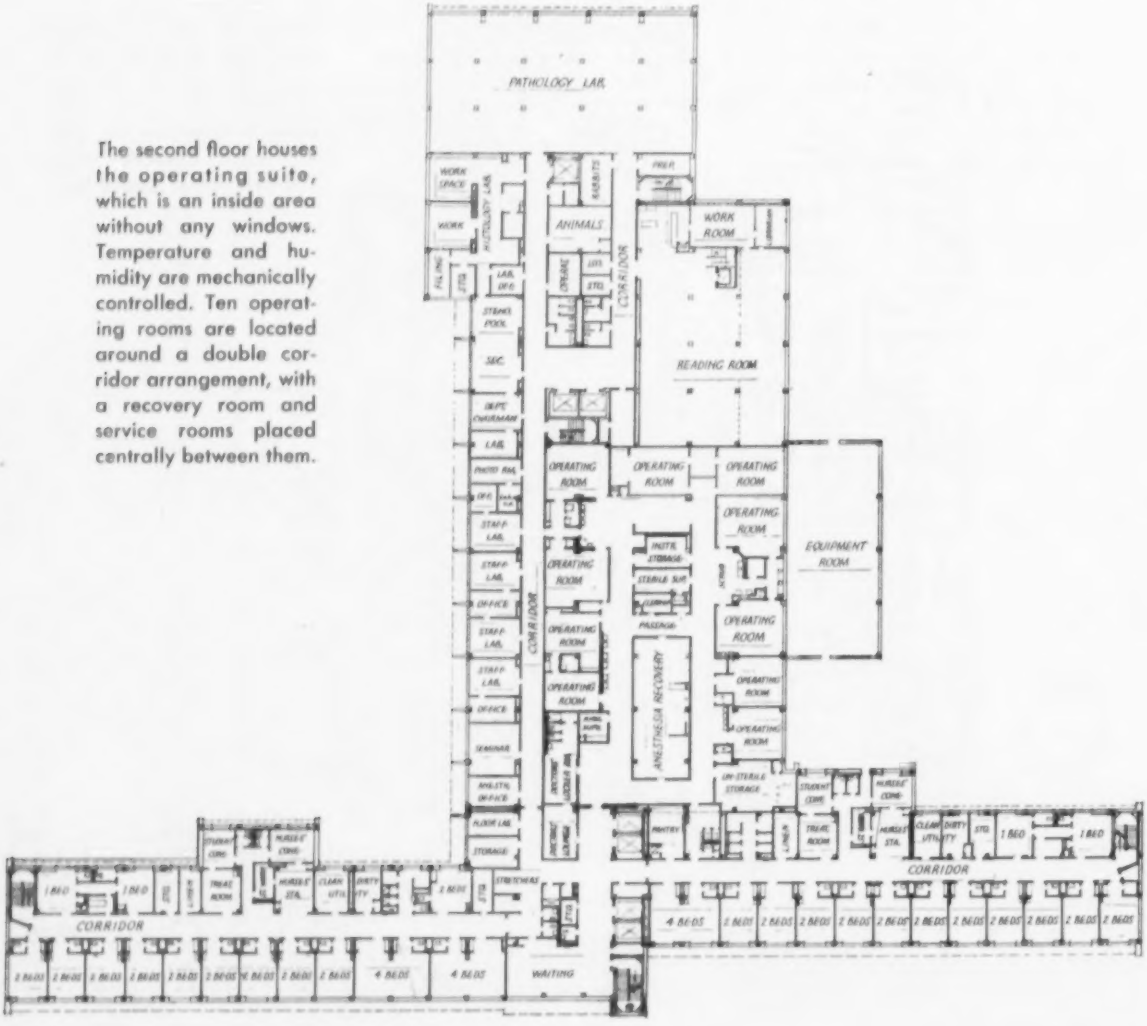
The x-ray department is located in the center of the building between the outpatient department and the emergency department. It was felt that these two departments (with mostly ambulatory patients) would have the greatest need for x-ray service. Only inpatients would need elevators to get to the x-ray department. For another convenience the x-ray area is located under the operating suite. A dumb-waiter is available to the operating suite and the developing room to make easy developing of films taken during various operations.

Central sterile supply is on the third floor between the delivery suite above and the operating suite below. Easy dumb-waiter service is available among all these units.

Most of the remaining service facilities are located on the ground floor, which is equal in size to the first floor. Located on this floor are medical records, printing, heart and lung station, central dictation, pharmacy, housekeeping, kitchen, stores, lockers, photography, cobalt room and morgue. This floor is at ground level on two sides, which permits outside area for office and kitchen facilities. It also permits a good location for a receiving dock. In the underground area ample inexpensive protection is available for the cobalt therapy machine.

A great deal of emphasis was placed

The second floor houses the operating suite, which is an inside area without any windows. Temperature and humidity are mechanically controlled. Ten operating rooms are located around a double corridor arrangement, with a recovery room and service rooms placed centrally between them.



on the housekeeping department as this department was planned to assume the housekeeping activities of the entire medical center under a single director.

Adequate provision was made for the storage of heavy equipment, housekeeping supplies, a central linen depot, and a uniform control unit. A sewing, repair and manufacturing center was provided at a factory level. A teaching and demonstration unit was given careful consideration so as to provide space for a combined training program for both housekeeping and dietary workers.

The building has a ground floor, seven regular floors, and a penthouse, which is used as sleeping quarters for employes who are required to be in the hospital at night on call. Almost half of the floor area of the building is in the ground and first floor.

The operating suite, located on the second floor of the building, is an inside area without any windows. The temperature and humidity are mechanically controlled. Ten operating rooms are located around a double corridor arrangement to permit a recovery room and service rooms to be located centrally between them. The recovery room has 10 beds and adequate service facilities.

The delivery suite is similar in construction to the surgical suite. One of five delivery rooms was planned and is set up for obstetrical surgery only. In addition to the delivery rooms there are six acoustically treated labor rooms and one preparation room. Six small rooms are provided for sleeping visiting staff, house staff and students.

Patient rooms occupy six floors. There are two nursing units to the floor. Between the nursing units is a large area which is used for four elevators, stretcher and wheel-chair storage, and a large combined solarium and visitors' waiting area. This central area is large because a future addition is planned to originate at this point.

Nine medical and surgical nursing units have 30 beds each; two obstetrical units have a total of 42 beds, and one pediatric unit has 38 beds. Each nursing unit has a basic central service area which was designed specifically with medical and nursing students in mind. Each area has a conference teaching room for nursing students and also a similar room for medical students. The medical students also have a small room immediately adjacent to the nurses' station where they can write up patient records. A revolving chart rack permits nurses or medical students to obtain the patient charts without having to enter the other's area. The nurses' station is an administration area only. A separate room is provided for medication preparation and other supplies. Another separate room is provided for dirty supplies, dirty instruments and dirty linen. Finally, a separate storage room is available for storing large equipment when not in use. A linen room and a treatment room complete the service area.

Approximately two-thirds of all patient beds are in two-bed rooms. Some four-bed units are available and also a few private rooms. This distribution of beds was selected to ensure flexibility and cut construction costs, and because a large number of service patients who could not pay the full costs of hospital care were expected.

Throughout the planning phase at least two specific thoughts were always kept in mind: (1) What space arrangement will require the least travel and the most efficient setup for nursing personnel? (2) How can medical and nursing education be served without interfering with personnel immediately responsible for routine patient care?

(For description of architecture and interior design, see pages 62 to 64.)

A view of the patients' tray assembly section of the kitchen. Patient serving is handled by means of a tray distribution system. It was assumed that about 50 per cent of patients' meals would be special diets and these special trays are prepared in separate section of the kitchen.

OUTLINE OF CONSTRUCTION COSTS

HOSPITAL ONLY		
Gross floor area	224,500 sq. ft.	640 sq. ft. per bed
Volume of building	3,045,000 cu. ft.	8700 cu. ft. per bed
Construction contract	$18.82 per sq. ft.	$1.38 per cu. ft.
	$12,070.00 per bed or	$4,224,507.00
Total project cost	$22.21 per sq. ft.	$1.64 per cu. ft.
	$14,300.00 per bed or	$5,000,000.00
MEDICAL SCHOOL		
Gross floor area	243,500 sq. ft	— sq. ft. per bed
Volume of building	3,320,000 cu. ft.	— cu. ft. per bed
Construction contract	$15.40 per sq. ft.	$1.13 per cu. ft.
	— per bed or	$3,753,073.00
Total project cost	$16.45 per sq. ft.	$1.20 per cu. ft.
	— per bed or	$4,000,000.00
COMBINED		
Gross floor area	468,000 sq. ft.	1,330 sq. ft. per bed
Volume of building	6,365,000 cu. ft.	18,200 cu. ft. per bed
Construction contract	$17.05 per sq. ft.	$1.25 per cu. ft
	$22,800.00 per bed or	$7,977,580.00
Total project cost	$19.23 per sq. ft.	$1.41 per cu. ft.
	$25,700.00 per bed	$9,000,000.00

THE INTEGRATION OF A HOSPITAL WITH A MEDICAL SCHOOL

EARLY consideration determined that the most economical situation would prevail if the medical school and the teaching hospital were integrated, one with the other, by designing a single building to house all facilities. This integration imposed on the architects' design staff a rather unusual problem.

Following are salient problems that required consideration:

1. The determination of a common story height suitable to both the medical school and the teaching hospital, so as to permit of floor levels being uniform throughout. Anything beyond 10 feet floor to floor for the hospital area could have been considered extravagant, yet at the same time 10 feet floor to floor in the school area would have cramped the large area rooms such as laboratories and lecture rooms. A happy 11 feet 6 inches was established as a common floor height from second floor up through the seventh floor level.

The need for providing adequate and accessible mechanical and electrical distribution systems, as well as the decision to make the medical library multistory with stack levels directly under the main reading room, established a 15 foot story height between ground level and first floor and between first floor and second floor. This produced stand-up access to the mechanical and electrical installations above suspended ceilings where these were determined to be advisable almost throughout the first floor area. Also, the clear and undisturbed high areas in storerooms on the ground floor have proved to be extremely worth while.

In a story height of 15 feet it was possible to incorporate two stack levels 7 feet 6 inches floor to floor under the library main reading room, thereby making available four stack levels confined within the space taken by the main reading room and producing a most economical and satisfactory medical library arrangement.

Mr. Naef is a partner of MNO Associated Architects (E. L. Malvaney, R. W. Naef, and N. W. Overstreet), Jackson, Miss. This article was prepared in cooperation with William L. Gill, project supervisor representing the architects.

WHY THE COLORS ARE WHAT THEY ARE

ELIZABETH KINGSFORD

THE sphere of travel of the individual in a building of this size is usually limited to one wing of one floor and the path to the entrance. Color chosen by the wing or floor with this limited travel could become very monotonous to the casual visitor and the patient. To avoid this possibility we coordinated our color selection in vertical rather than the usual horizontal planes. This led automatically to the use of functional color (*i.e.* the function of the room dictating the color) and at the same time posed the serious problem of choosing compatible colors. All fixed or permanent colors were made a neutral warm gray. Among the items given this neutral gray are doors, door frames, wood and metal casework, floor tile, ceramic and structural tile. A great deal of study was put into the selection of this gray to avoid the possibility of limiting the choice of primaries for this and future paintings.

After our study we concluded that the dominant factors of color psychology are brightness and visibility. The effect of hue, or specific color, is influenced by personal preference, style and individual color response. In a building such at this, with its high percentage of interior rooms, the primary consideration should be given to counteracting the psychological effects of enclosed spaces. Therefore, interior rooms were given a feature color near the center of the visible spectrum, *i.e.* orange-yellow, yellow, yellow-green. Color for the patients' rooms was chosen to simulate as far as practicable currently popular residential colors. By using a group of three colors and varying the position of these colors in the rooms, it was possible to give the effect of a wide range of color. This effect, coupled with the functional color of the service areas of the patient wing, gives to the casual visitor and the patient an exceedingly wide range of color.

The choice of color for patients' rooms was made on the following basis: For surgical patient rooms, a complement to the green of the surgical suite; for obstetrical rooms, a range of pink and blues; for the medical rooms, green and tan for one floor and, blue for the second medical floor.

We also used the patient room colors in the corresponding clinics of the outpatient department. In the basic science wing the laboratories were painted in rose-tans in an effort to produce the best possible natural light conditions. Painted wainscots in this section were done in a fairly dark shade of gray-blue. The functional color of the service areas from the hospital was repeated to give a desirable contrast.

LOBBIES ARE BLUE AND ROSE

The public lobbies were given shades of metallic blue and dark rose to produce a subdued atmosphere in an effort to reduce the amount of unnecessary noise. In contrast to the lobbies the floor waiting rooms were painted in bright shades of yellow and dark foliage green with one common red brick wall to produce a pleasant informal atmosphere.

Mrs. Kingsford is assistant to the director, University Medical Center, Jackson, Miss.

CALLED FOR SOMETHING DIFFERENT IN DESIGN

R. W. NAEF

Early in our study of the basic requirements we were struck by the similarity of the processes of the medical center and those of industry. Further study along this line narrowed the processes down to four. One of these, the housing of students, was eliminated by budget requirements. The other three were: patient care, medical arts and medical education. Each of these processes, studied individually, predicated a basic structural module.

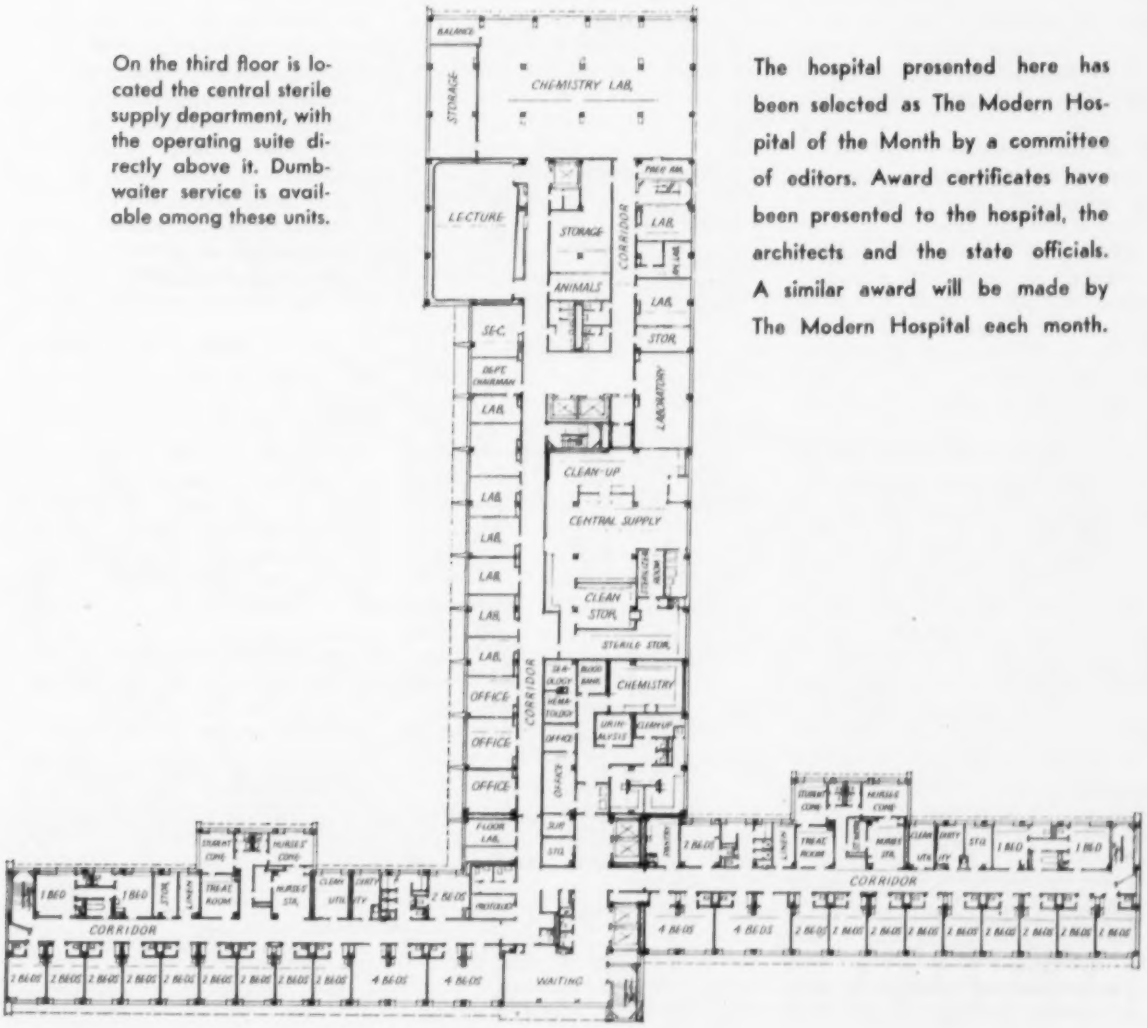
Patient care resolved itself into a basic module 13 by 16 feet. Assembly of these modules into the recommended groupings set the pattern for the hospital section. The patient module, percentage-wise being by far the major portion of the hospital, was used as the basis of the design of ancillary facilities. Nurses' stations, utility rooms, linen rooms, nurseries, and student conference rooms were designed to fit this module rather than to assume a module of their own.

Study of the process of medical arts led us to accept the surgical suite as the designing factor. We satisfied these requirements with an 18 foot square module. Projected down, this unit served quite well for the radiographic suite and a cafeteria on the main floor and kitchen on the ground floor. Above, it satisfied the requirements of the central supply, hospital laboratory, and obstetrical suite.

The medical education process was designed around the minimum efficient width of a laboratory unit. In most cases this was found to be 8 feet. However, in some cases it was found desirable to increase to 9 feet, thereby establishing an 18 by 16 foot module. Six of these units, combined into a single unit with the center row of columns left out, established the typical lecture room, the lecture room being 1700 square feet, or seating for 150 in one group or divisible into smaller lecture rooms.

The use of these three basic modules led us to a simple concrete structure and greatly reduced the cost. The form work was standardized and reusable throughout. Not only was our cost factor reduced by the use of these struc-

On the third floor is located the central sterile supply department, with the operating suite directly above it. Dumbwaiter service is available among these units.



The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

tural modules, but our planning time was also greatly reduced. In determining depths of beams, consideration was given not only to required design depth but also to coursing out partition blocks or tile. Depths were increased to meet full coursing dimensions, thereby obtaining economies by eliminating cutting of masonry units. Using the modules as building blocks, we arrived at a gross plan that was not committed to detail. It has been our experience that a building designed around modules established upon intrinsic function retains throughout its life sufficient flexibility to comply with process changes.

After visiting a number of large medical centers, we determined to arrange for separation of medical students from the hospital staff, especially around nursing stations. Examination of the plans will reveal that the medical students have been provided with their own facility and without too much expensive floor space being allocated. It will also be noted that the medical students have private access to medical charts and that they have been provided with a private conference room immediately adjacent thereto, private toilet facilities, and a private examination room, all forming a unique and functional suite.

An unusual plan for handling both vertical and horizontal transportation has been devised in order to prevent inpatients' and outpatients' traffic from mingling indiscriminately with visitor traffic. The outpatient area has its own main private entrance and is confined on one floor, thereby eliminating the need for vertical transportation to handle this load. The five departments in the outpatient area have adequate and separate waiting facilities immediately adjacent to examination and consultation services as required. Separated from the four main hospital elevators are two medical student elevators located within the medical or north wing. Two of the four main hospital elevators are fully automatic and are generally used for staff and services, the other two being manually controlled and used basically for the vertical transportation of visitors.

Every known precaution for safety for both patient and hospital employe has been incorporated into the structure. Five emergency fire towers run the full height of the building. The standpipe system is supplied from two separated water systems, namely, city water system and house system, which is generally supplied by two deep fresh water wells.

The obstetrical unit and nurseries occupy the fourth floor. The delivery suite is similar in construction to the surgical suite. One of five delivery rooms was planned and set up for obstetrical surgery.

Quality Has to Be Nurse Educators' Goal

A nursing leader refutes the contention of a hospital administrator that nurses are being overeducated at the expense of the over-all needs of hospitals for nursing service

JANET M. GEISTER, R.N.

WHILE nurses have always been the favorite whipping boy for whatever goes wrong or is missing in patient care, they show some improvement. Apparently the faults lie mainly now with the nurse educators, especially those in the upper tiers who set the standards. However, what Dr. Thomas Hale lacks in the breadth of his target is made up for in the magnitude of the wrongs charged against the educators.* One of the paradoxes of the nursing situation is that while nurses work endlessly and earnestly to find answers to their problems, there are always non-nurses who already know these answers.

SERVICE IS ANATHEMA?

"It is the tragedy of nursing," says Dr. Hale, "that the term 'service' has become anathema in nursing education circles today." He finds no evidence that nurse educators "are becoming more sensitive to the plight of the hospital." In their stress on quality instead of quantity in these days of ever-increasing stress on hospitals, they contribute directly to the shortage of nurses, to the hospital's inability to furnish adequate round-the-clock service to patients, and to the dissatisfaction of patients. The costs of operating nursing schools are up; they should not be added to the patient's bill, nor met by tax money. Rather the student should be provided more opportunity to earn her way.

These charges, and still others, reveal a point of view strangely at variance with today's actualities. It fails to recognize the profound influence on nursing education and practice of the health revolution of the past half century. Every group in our society has felt the impact of the swift and wide advances of science, and all are in some state of transition. But none has had so overwhelming a challenge put upon it as nursing, which today is in what one writer calls "a period of torturous transition."

Science has brought a vast new knowledge of the causes of man's diseases and of man himself—and thus literally turned the old morbidity and mortality tables upside down. The life expectancy span has been doubled since 1890. The place young people with acute diseases once had in our hospitals has been taken over by a growing army of older people with the chronic diseases that require longer, more complex care. Awakened health hungers have brought an extension of health facilities, including thousands of new hospital beds, far greater than anyone would have dared predict a few decades ago. The population grows steadily, and the mechanization of industry, transportation, homes and farms has enormously increased the accident rate.

The shortage of nurses today is by no conceivable standard the fault of the nurse educators; it is simply the result of sheer volume of new demands for health care. Never in all history have so many nurses been actively at work as today, nor has so much auxiliary service been available. Since 1940, 435,000 nurses have been graduated from our nursing schools. In 1954, there were 120,735 full-time general duty nurses employed in our hospitals; 36,330 more on part time; 62,142 supervisors, head nurses and their assistants, and more than 10,000 nurses in administrative positions. This is in sharp contrast to the scant 3000 staff nurses we found in the early Thirties. The pressure of 351,765 auxiliary workers (practical nurses, attendants, nurse's aides, orderlies and ward maids) is in even sharper contrast.

Furthermore, nurses do not, as in the past, meet only the patients brought to them in hospitals, but go out to them in a multiplicity of health services that reach our people wherever they live, work, go to school, or visit a doctor's office or health clinic. The great number of hospital personnel is not essentially a replacement of student services but represents a wide expansion of services.

CLASSES GROWING LARGER

It is utterly fallacious to imply that the raising of educational standards and the closing of some schools result in losses to the student body. The facts are quite the contrary. In 1955, in 1125 schools of nursing—less than half the number that existed when the Committee on the Grading of Nursing Schools made its study—there were 107,572 students. Except for the three war years of the cadet program this is the highest enrollment on record. Classes are steadily growing larger as the number of schools goes down. There were 16 fewer schools in 1955 than in 1954, but 1568 more students.

Volume of new work is only one side of the story. Nurses not only have more patients to care for but many more things to do for them—time consuming, skill demanding

*Hale, Thomas, Jr.: Too Much Education for Too Few Nurses? Mod Hosp. 86:75 (June) 1956.

things. In the days when typhoid, pneumonia, puerpural septicemia, peritonitis, and similar acute diseases predominated, care was prolonged but the nursing procedures were simple in comparison with today's. In the new scourges of chronic diseases, science has furnished multiple new weapons for early diagnosis and more comprehensive treatment. The stress is not only on staving off death as in the past, but on prevention, restoration, rehabilitation. The order books fattened fast. Early ambulation fattened them even more. The shorter the hospital stay, the more concentrated became the care, and the more swiftly the nurse had to move. That was a main reason for cutting the working day to eight hours.

As the doctors became busier, they delegated more and more long, skilled procedures to nurses. The California Medical Association, for example, in discussing the legal implications of the administration of intravenous fluids by nurses, stated ". . . this is a time consuming procedure which can be more economically provided to the patient by the nursing personnel. . . ." This is just one of the lengthy, skilled tasks that have been turned over to nurses.

CURRICULUM REFLECTS ADVANCES

How can the nurse educator prepare the nurse adequately unless the curriculum reflects the advances in the biological and chemical sciences? The curriculum is built not on the fantastic ideas of nurse educators, but on the stark demands placed on nurses. Every specialist, every general practitioner *expects* the nurse to know how to interpret and carry out his particular emphases, and he complains bitterly if she cannot do so. Today's advanced surgery, such as on hearts, brains, lungs and nerves, calls for a quality of nursing skill and critical judgment far beyond that needed in an earlier day.

Nurses capable of meeting today's needs are the products of the most thoughtful curriculum that conscientious educators can devise out of recognized demands—and these educators never stop their critical evaluations of their programs. Dr. Hale agrees that "the great number and tremendous complexity" of the new drugs demand a "very thorough knowledge" of certain aspects of pharmacology—that the nurse "must know how to interpret doctor's orders and give the patients the exact medications ordered by their physicians." Is this the "very thorough knowledge" he advocates? Would any knowing person want his medication measured and administered by someone who doesn't know too the nature of today's powerful drugs, their toxic potentialities, their dosages according to age and conditions, their probable effects?

Dr. Hale's whole attitude seems to be that the nursing school is operated primarily to provide service to the hospital, and only secondarily to prepare young men and women for lifetime work. How else can we justify his plea for a sacrifice of quality in favor of quantity in this period of "ever-increasing pressure on the hospitals"? Yet he uses the term "education" for a type of apprenticeship no other form of education would tolerate for a moment. Where in the education of doctors, dentists, lawyers, or any other profession do we find anyone advocating that students give services in return for any part of their education? Why should nurses who are so essential to every health program be the exception?

Is hospital economics the prime consideration, or is the welfare of patients? What about the patients the graduates of "quantity first" schools will care for? Who would employ these graduates and give them opportunity for advancement? Certainly, not the doctors. The youngest age group in nursing today are those in doctors' offices. For their youth? Or because they have been well grounded in the nursing aspects of the very latest in medical practice? And where would we get enough recruits? It is an established fact that the higher the standards of the school the more prospective students come to the door. High school graduates are being counseled to hunt out the well accredited schools in any field they will enter; they know there are long years ahead; and young women are realizing that the possession of a recognized skill is an invaluable asset for meeting the uncertainties of life, married or single.

Contrary to Dr. Hale's opinion, nurse educators are well aware of and sensitive to the increased costs of nursing education. It is a subject that is constantly in their discussions. Some of the deep and complex aspects of the matter are put forth clearly in "What Are the Issues?" [in the evaluation of student services] in *Nursing Outlook* for May 1956. There is no pat answer to the question of who or what should bear the burden of nursing education. In general education, taxes, grants, gifts and earnings fill the wide gap between the tuition paid by medical, legal and other professional students and actual costs. Nursing education, the odd sister, remains largely dependent upon hospital economics. The answer lies *not* in shortchanging the student's education by having her fill the gap between costs and tuition through earnings. Nurse educators did not establish nursing schools in hospitals; that was done by hospitals to get inexpensive service. The answer as to how much of this function should be transferred to other sources can be found only through experiment, cooperation, and mutual understanding of all the factors involved—and not by dictum.

BEYOND NURSES' CONTROL

How can any conscientious person recommend stress on quantity over quality in the realm of human care? Why not, instead, attack the conditions beyond nurses' control that militate against their giving good care? Does every admitted patient actually need the high powered and costly setup of hospital care, or are some there because it is more convenient for the doctors? The greatest single cause of nurses' discontent with hospital nursing is the loss of job satisfactions, and that loss is inevitable when a nurse can only touch the high spots and leave all the old, warm personal contacts with patients to others. Most nurses want to do good nursing and they want their patients well cared for. Dr. Hale cites the Dichter study of patient dissatisfaction. Dichter's patients did not complain of the nurses; they complained of the depersonalization of their care, a factor quite out of nurses' control. Patients are put on the assembly line, and the nurses must follow them there—and neither has any use for the place.

Other factors beyond nurses' control work against the best use of the available supply of nurses. Inelastic employment arrangements for married nurses with families is one. Dr. Hale, in blaming the nurse educators for nurses' reluctance to do night, weekend and holiday duty, ignores the pull of family responsibilities. There are hospitals that have done well in meeting the married nurse halfway in making adjustments between family and professional life.

Dr. Hale states that the policy of limiting school enrollment to the size of the faculty is "open to challenge. Many present hospital schools could admit more students without adding to their faculties." We wonder what is his authority for this statement. If the main idea is quantity production he is probably right. But nurse educators are held responsible for the kinds of nurses they furnish the community, so they are rather stubborn on the subject of quality. A recent survey brought reports from hospitals in 43 states that their greatest shortages were in faculty and supervisory personnel.

He also suggests that supervisors do part of the teaching. "If one more job is handed to the supervisors," declares a nursing director, "we won't have any at all. They'll be dead from overwork and no one will risk taking their places." Supervisors are *always* teaching but at the bedside, not the classroom. But administering a ward and classroom teaching are two distinct fields; both call for special traits and special preparation.

WHY DO THEY WORK SO HARD?

In view of Dr. Hale's declaration that nurse educators give little thought to the effect of their policies on patient care, we wonder then why they work so hard at recruiting, why they put on experiments and studies to find answers to their questions, why they are trying out the two-year schools for "bedside nurses," why they push the establishment of schools of practical nursing, and the use of qualified practical nurses. Today a goodly part of the "torturous transition" lies in the concurrent experimentation with one-year, two-year, three-year, four-year and five-year schools in efforts to learn what kinds of nursing today's patients need and how much of each. It takes courage, conscience and a real ardor for adequate patient care to undertake such broad experimentation.

So acutely aware are nurse educators and all nurses of the nursing needs of our people—including hospital patients—that the National League for Nursing was specifically organized to bring into conference and action the ideas, knowledge, experiences and help of representatives of every group concerned with health. Here doctor, hospital administrator, businessman and educator, as well as the consumers and producers of nursing, meet on the common ground of their interest in adequate nursing care for our people. Is this a sign of indifference?

A final charge appears in Dr. Hale's statement that nurse educators, in improving the general cultural background of nurses, make them extremely eligible marriage candidates! If recruiting officers would seize upon and broadcast that fact, it is doubtful if any other recruiting efforts would be needed.

"Holy Discontent" Is Key to Progress, Cardinal Stritch Tells Catholic Delegates

Msgr. J. B. Brunini

Msgr. R. A. Maher

MILWAUKEE. — "Holy discontent" was named as the key to progress in hospital administration by Samuel Cardinal Stritch, archbishop of Chicago, in his opening address to the 41st annual convention of the Catholic Hospital Association which met here last month.

With 5700 Catholic hospital workers in attendance, the convention was the largest in recent years, it was reported.

University training of hospital administrators is not sufficient, Cardinal Stritch said in his address. To this basic knowledge, specialized training must be added, he explained, and training must be a continuous process. "Calm discontent is the key to progress," he stated. "Let us not be content. Let us all have a holy discontent."

Care of hospital patients must comprehend the soul as well as the mind and body, the Cardinal declared. Religious and other hospital workers must never forget the dignity of man, he said.

"Every patient admitted should come in personal contact with the Religious," Cardinal Stritch concluded. "It would be a splendid thing if such religious contact could be maintained and extended beyond the walls of the hospital. Sister-trained workers might well be used to follow up on the welfare of patients after dismissal from the hospital. All the work of patient care cannot be done within the period of hospitalization."

Rt. Rev. Msgr. Joseph B. Brunini, Jackson, Miss., became president of the association during the convention, succeeding Rt. Rev. Msgr. Robert A. Maher of Toledo, Ohio. Monsignor F. M. J. Thornton, Seagirt, N.J., Bishop's representative for hospitals for the diocese of Trenton, was named president-elect to succeed Monsignor Brunini next year.

Within a few years, hospitals will be making their own isotopes for use in the diagnosis and treatment of disease, an industrialist predicted in an address on the opening day of the convention.

"Progress in the development of tools useful in the field of diagnosis in hospitals in this atomic age will soon be accelerated by widespread use of small, very low-powered reactors which will produce and store radioisotopes," Charles F. Burke, assistant to the president of the General Tire and Rubber Company, Akron, Ohio, told the convention. "This will make isotopes, especially short, half-lived ones, as immediately available as antibiotics stored in hospital refrigerators. The immediate availability of these isotopes may well open up many new vistas in the hospital field."

One of the big problems in medical application of isotopes today is the necessity for transporting materials to hospitals from the A.E.C. reactor at Oak Ridge, Tenn., Mr. Burke explained. "With a small, very low-powered reactor, these isotopes would be immediately available in the hospital," he said. "It is merely a matter of taking the stored isotopes from the reactor. Relatively, the small reactor is just like a refrigerator. Essentially, we have a nucleonic refrigerator.

"This low-powered reactor can be installed and used in the ordinary hospital laboratory with absolute safety and without the costly building, shielding, danger and maintenance connected with such high-powered units as at Oak Ridge.

"You can, figuratively speaking, roll it into an existing room in the average

(*Continued on Page* 162)

Practical Nursing School Pays Its Way

Graduates of Mount Sinai's school fill an indispensable place in the nursing department, the administrator reports, and enables the hospital to provide better care at lower cost

FLORENCE S. HYDE

SOON after Mount Sinai Hospital at Miami Beach, Fla., was opened to patients in 1949, it faced up to the problem of dealing realistically with the shortage of professional nurses in staffing an institution with 258 beds and 50 bassinets.

"We were training and using nurse's aides but felt the need of auxiliary nursing personnel with more adequate preparation," said Executive Director Samuel Gertner. "We discarded the idea of a registered nurse school as too expensive and, when Florida passed a practical nurse licensure law and set up standards for training in 1951, we decided that our own school of practical nursing offered the best hope of training needed nursing personnel at minimum expense. Now, after four years, we are more than satisfied with the results.

"Our graduates are filling an indispensable place in the nursing team setup and enable us to provide good nursing care at lower cost. The community has accepted the licensed practical nurse who has completed our course as a well qualified member of the nursing team. From the beginning of our program, we have had the cooperation of our professional nursing staff in accepting this newcomer into the nursing group and in helping in every possible way in the clinical training of our students.

"We are greatly indebted to our women's auxiliary for underwriting the major portion of the net cost of operating the school, using profits from their snack bar and gift shop for this purpose."

Tangible proof that the hospital's board of trustees shares the views expressed by Mr. Gertner is found in the expenditure of $15,000 within the last year to enlarge and improve teaching and residence facilities and also in the substantial increases in clinical student stipends and the allowances credited in the school budget for services of junior and senior clinical students. Salaries of faculty members and others on the school staff also were increased.

Previously, teaching facilities were sufficient only for from eight to 14 preclinical students but enlarged facilities made it possible to admit a class of 24 in October 1955. Another class of 14 was admitted on Feb. 27, 1956.

As of March 1, 1956, 22 graduates of the school were employed on the hospital nursing staff and 18 junior students were giving valuable services as a part of their clinical training. There were no senior students owing to the

Mrs. Hyde is a former executive secretary of the Illinois Hospital Association and is now engaged in hospital public relations work and free lance writing.

Practical nursing students at Mount Sinai Hospital, Miami Beach, Fla., receive a total of 522 hours of classroom instruction in the preclinical period. Here, a mannequin is used to demonstrate a nursing procedure.

omission of the June 1955 preclinical class.

In common with most nursing schools Mount Sinai loses some graduates to marriage and motherhood and some who return to their home areas to engage in active practice. Last year the school had students from five other states, one from England and one from Israel.

OPERATED BY HOSPITAL

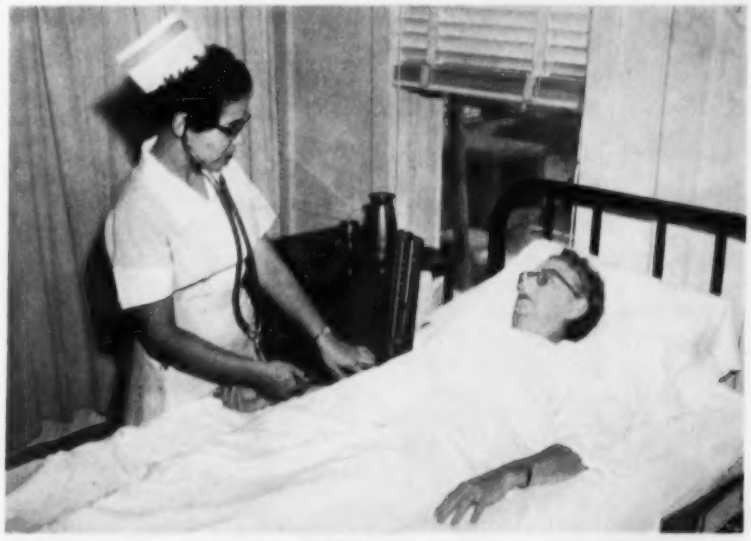
Mount Sinai school was one of the first state approved practical nurse programs in Florida. It is the only such program in Florida accredited by the National Association for Practical Nurse Education and the only one in Florida operated entirely by a hospital. There are 11 state approved practical nurse programs in Florida which are sponsored by vocational education with clinical training provided by hospitals.

The one-year program at Mount Sinai embraces 16 weeks of preclinical instruction, 33 weeks of clinical instruction and experience in the hospital, and three weeks' vacation. Students have eight holidays during the year and most week ends off. The scope of the teaching program is somewhat broader than in most approved schools. Classroom hours in the preclinical period total 522 while 172 hours are allotted to classroom and ward instruction during the clinical portion of the course, making a grand total of 694 hours of organized instruction, not including incidental conference sessions with faculty members.

Carmen F. Ross is the director of education in charge of the program. In addition to being a registered nurse, Mrs. Ross has a B. S. degree from Adelphi College and an M.A. degree from Columbia University. Her experience includes 10 years of nursing education and public health nursing with public and voluntary agencies. Besides her duties as director, she does some teaching in both the preclinical and clinical areas.

There are three other full-time registered nurse faculty members, including a nursing arts instructor and one assistant who supervises students in the hospital in cooperation with head nurses and team captains, and a clinical instructor who gives class instruction, conducts ward conferences, and discusses casework studies. Two have B. S. degrees and the third is studying for a bachelor's degree in nursing at the University of Miami. A substitute teacher in the Dade County public schools is employed part time as home economics and nutrition instructor in the preclinical program.

The study of anatomy is an important part of the practical nurse student's training. After studying the anatomical model of a brain, the instructions for the care of lobectomy patients will be more meaningful.



In the clinical phase of their training, students learn to assist the professional nurses in the care of postoperative patients. Here, a student takes a blood pressure reading which she will enter on the chart.

According to the school budget set up for 1956 on the basis of an estimated enrollment of 40 students in training, the net cost per student will be approximately $700 for the one-year course. To this should be added about $75 per student to cover certain operating expenses assumed by the hospital but not included in the school budget.

The total of $56,640 budgeted for expenses includes salaries, student stipends, food, laundry and linens, school and residence supplies, health expenses other than Blue Cross hospitalization, and salary of school physician, library, and public relations.

Income budgeted at $29,000 includes $6000 to be received for tuition and $23,000 to be credited for student services on the basis of $75 per month for four months each by junior students and $125 per month for four months each by senior students. The deficit of $27,640 has been underwritten by the women's auxiliary as stated by Mr. Gertner. The operating items not in-

cluded in the school budget and underwritten by the hospital include some health expenses, electricity, water, telephone, postage, and repairs and maintenance of the school and residence.

In this connection it should be stated that students are provided with room and meals, laundry of uniforms, health supervision and treatment for conditions developed while a student, and textbooks. Blue Cross hospitalization insurance is provided during the preclinical period but junior and senior clinical students pay their own Blue Cross fees.

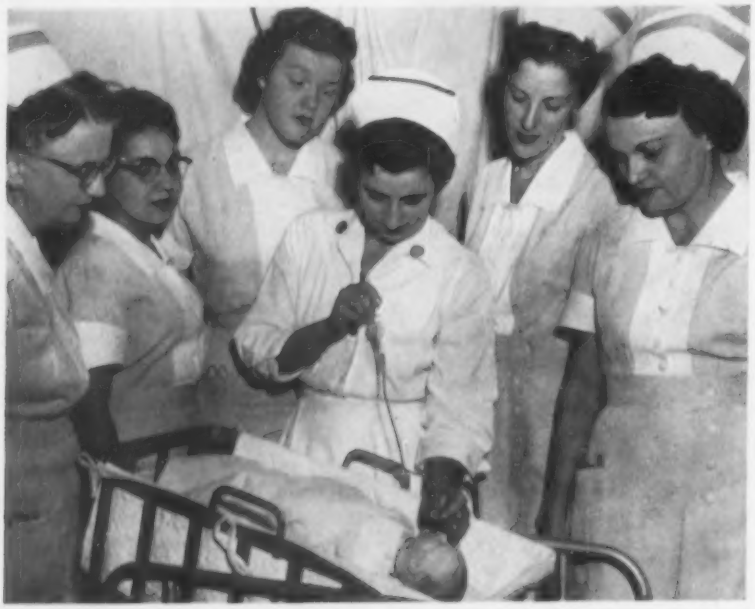
Other expenses met by students include $150 for tuition, $5 fee for preentrance psychological test, and $30 for uniforms at the beginning of the course. They also pay for uniform replacements, graduation uniforms and other items at graduation. On the other hand, junior and senior students receive stipends of $15 per month. Thus they receive a bargain package after the tradition long followed by hospitals as sponsors of nursing education.

It cost Mount Sinai Hospital $25,000 at the outset to remodel and equip a two-story structure near the hospital to provide teaching facilities and residence quarters. Additional remodeling and equipment involved further expenditures of $15,000 in 1955.

Present teaching facilities for a preclinical class of at least 24 students include: nursing arts laboratory with seven complete hospital bed units, adult, child and infant dolls; lecture classroom with motion picture and filmstrip projectors, skeleton, torso and charts; food and nutrition laboratory with stoves and all necessary kitchen equipment; well stocked library, instructors' offices, and conference rooms.

Residence quarters include private and semiprivate rooms, social rooms, television lounges, outdoor patio, snack room and other facilities for pleasant living. Students have the use of the swimming pool and other recreational areas provided for hospital personnel.

A faculty member supervises each clinical student until she has demonstrated her ability to perform all nursing procedures. An instructor watches as a practical nurse gives a hypodermic injection to a patient.



Classroom and ward instruction are integrated with clinical experience in the OB department. In preparation for their obstetrical nursing experience, senior clinical students learn technic of newborn resuscitation.

OBJECTIVES OF THE PROGRAM

Briefly stated the objectives of the Mount Sinai educational program are: (1) to prepare qualified applicants to become graduate practical nurses, eligible for state licensure on passing the examination; (2) to prepare good bedside nurses who, under the supervision of the registered professional nurse and/or the licensed physician, will be capable of performing and assisting with the procedures necessary in total patient care; (3) to have the student and graduate become qualified to work harmoniously as members of the health and nursing teams in meeting the total needs of the patient and his family; (4) to prepare the student and graduate as better members of the nursing profession, their families and the community by defining the rôle of the practical nurse and her responsibilities as a citizen and a nurse; (5) to interpret practical nurse education to the community through an effective public relations program and an accredited instructional program.

In order to attain these objectives, Mount Sinai has developed a program which is notable for its continuity and effective integration of instruction with clinical experience. Having the entire

program in charge of the hospital's director of education and carried out in the main on hospital premises is an important factor in achieving desirable results. Another important factor is the team setup in the hospital's nursing department which facilitates the clinical training of students and utilizes to good advantage the services of graduate practical nurses.

Although the organization of the nursing team varies in different services and for different shifts, a good example is found on a medical floor with 60 beds, four wings and two nursing stations. Here the professional nursing staff consists of the unit supervisor, one head nurse and four team captains (plus two team captains for relief). Fourteen other members of the team staff include eight licensed practical nurses (plus four for relief), two aides (plus one for relief), two orderlies (plus one for relief), and two nursing clerks. Staff planning is on the basis of a 40 hour week.

The head nurse and team captain identify the patient's nursing needs for the graduate and student practical nurses. The team setup of the nursing department facilitates the clinical training of students.

Carmen F. Ross, director of education in charge of the program, giving classroom instruction to students. In addition to Mrs. Ross, there are three full-time R.N. faculty members and a part-time nutrition instructor.

WORKS UNDER TEAM CAPTAIN

The licensed practical nurses work directly under the registered nurse team captains from whom they receive their patient assignments and instructions at the beginning of the shift. The team captain assumes responsibility for patients who are critically ill or who require skills that only the professional nurse is qualified to utilize. However, the practical nurse is able to give most of the routine bedside care and to recognize any developments in the patient's condition that should be reported promptly to the team captain.

During her clinical assignments for nursing experience the student is assigned by the head nurse to a nursing team where she works under the direction of the registered nurse team captain. All nursing arts procedures during this time are supervised by members of the school faculty until the student is ready to carry out the procedure on her own. The head nurse and team captain then become responsible for the student's supervision, with the help and guidance of faculty members, in the care and treatment of patients on routine nursing arts procedures. These procedures include the giving of medications orally, hypodermically and rectally, with the exception of narcotics. Students may assist the physician and registered nurse in intravenous therapy but may not start or discontinue this.

Students have two weeks of clinical instruction and experience in the recovery room, during which they observe patients undergoing surgery but are not taught to assist in the operating room. They are taught immediate postoperative care and assist the professional nurse by taking blood pressure readings, checking pulse and respiration, and giving medications.

Classroom and ward instruction integrated with clinical experience in the obstetric department includes two weeks on postpartum service, three weeks in the nursery and formula room, and two weeks in the labor and delivery suite.

Clinical instruction and experience in pediatric nursing include a two-week affiliation at a local nursery school and two weeks in the hospital pediatric unit. Other clinical assignments include eight weeks each of medical and surgical nursing, two weeks in dietary department, and two weeks in outpatient department.

This clinical training program, preceded by 522 hours of organized preclinical instruction and practice, is producing practical nurses who, as stated by Mr. Gertner, are making a contribution to good patient care which fully justifies the hospital's investment in their education.

A Guide to Budget Management

Part 2—Preparing the Expense Budget

H. W. MAYSENT

ALTHOUGH hospitals, in the last few years, have adapted many of the methods and technics of industry to their own needs, they have been slow to accept the necessity for budgetary controls as an important tool of management. In the first section of this article last month, the fallacy of this unwillingness to make use of the budget and the procedure for preparing the budget income were discussed. In this section, the steps to be followed in preparing an expense budget will be explained.

A careful estimate that reflects the desires of the department heads must be made of the requirements of each department of the hospital for the coming fiscal year. This should be done item by item. It should be realized that in soliciting the department heads' cooperation in the preparation of the budget their opinion of departmental expenses will reflect a certain amount of procrastination, wishful thinking, and hopes for the future.

This estimate of expenses should show the needs of the departments for the following types of expenditures: salaries and wages, and supplies. A further breakdown for such items as miscellaneous, maintenance, repairs and so on will depend upon the size of the hospital and the ultimate use of the budget.

STEP 1—SALARY BUDGET

1. In part, the salary budget represents the hospital's philosophy on what it feels is good patient care. As suggested in the first section, the matter of a standard of service is the starting point for any budget. Since our society is a dynamic one, our services must be constantly analyzed so that our purposes will fit the needs of the community we are serving.

Inasmuch as hospital salaries or wages represent approximately 60 per cent of the total operating costs and this is the largest single item of expense in hospital operation, it behooves the administration to pay particular attention to the salary budget.

2. The first phase of a salary budget is to work up a position budget on the basis of current needs. The personnel department should keep on file a master list of currently budgeted positions. During the preparations for the coming fiscal year, a blank position form (see Exhibit 9) is sent to each department head with instructions to designate the number of positions and the amount of hours necessary to fulfill the duties of their departments or areas. Also, they are instructed to record the current salaries and any projected increases they desire for the members of their staffs.

3. As each position has a certain number of authorized productive hours, a productive hour schedule is devised

Exhibit 9—XYZ Hospital Budget Year Ending 19—

Position Budget

Department:_____

				RATE			INCREASES		
Code No.	Title of Position	Incumbent at Time of Budget Planning	No. Hours per Week	Hour	Biweekly	Mo.	Per Month	Date	Remarks

Exhibit 10—XYZ Hospital

Payroll Department

General Payroll Statement of

Productive Hours

Pay Period Ending_____

Department	Budgeted Productive Hours	Paid Hours	Sick Hours Paid	Vac. & Holiday Hours Pd.	Productive Hours	Total Productive Hours
Administration						
Business office						
Personnel						
Purchasing						
Dietary						
Etc.						

Mr. Maysent is assistant director, Lankenau Hospital, Philadelphia. This is the second section of his article on the budget. The third section will appear in the August issue of this magazine.

The author wishes to acknowledge the helpfulness of John Stagl, assistant director, Passavant Memorial Hospital, Chicago, in advising and guiding him in preparation of this material.

Exhibit 11—XYZ Hospital Budget Year Ending 19—
Labor Budget Recap

Department: _____

Month: _____

	Pay[1] Period	Pay[2] Period	Pay[3] Period	Reverse Last Month	Plus This Month
Net salary					
Projected increases					
Vacation relief					
Holiday allowance					
[2]Additions to budget					
Department head increase					
Maximum salary					
[3]Less adjustment percentage					
[4]Accrual for month					
Adjusted salary budget					

[1] Three spaces are provided as some months have three pay periods (on a biweekly basis).
[2] New positions, from part time to full time or work extra hours.
[3] "Water."
[4] Convert number of days to a percentage and multiply.

from the position budget. Each pay period the personnel department receives from the accounting office the amount of productive hours by departments. This can then be compared with the budgeted hours for position and hour control. (See Exhibit 10.)

4. From the position budget, with each position filled, the dollar amount is computed on a monthly and bimonthly basis; this results in the basic current salary budget to which are added additional considerations in the months that they will occur. Such additions are increases in budgeted positions heretofore not included, merit increases, relief and holiday expense.

The biweekly salary figure is then adjusted for the number of days in each month. The resulting total of the 12 months will yield the maximum salary budget. (All positions filled 365 days of the fiscal year.)

This maximum salary budget is then adjusted downward as experience indicates there will be unfilled positions, leaves of absence, unpaid sick leaves, positions filled at a lower salary, unused vacation relief personnel, and an employe replacement lag. The reduction is usually referred to as "water" in the budget. Again, the percentage of this adjustment factor will depend upon past experience. (See Exhibit 11.)

Careful planning for this type of salary budget will result in certain inherent controls. These may take the form of: (a) position control, (b) productive hours control, (c) salary expense control, (d) daily nursing hours report, (e) internal control—in that all increases must have been budgeted and approved by the budget committee.

STEP 2—OTHER EXPENSE ITEMS

Past experience for these expense items for each department should be prepared for the two previous fiscal years as well as the fiscal year to date. An analysis and estimate are made on this basis. This information of past experience and estimated expense is given to the department heads for their approval or suggestions (see Exhibits 12, 13, and 14). As in the other aspects of the budget, the ultimate acceptance of amounts of these expense items rests with the budget committee.

In the process of compiling the past experience records, an effort should be made to locate the large expenses and designate them in the months in which they occur (as A.H.A. dues and other local or state organization dues). It is acceptable practice to anticipate months when exceptionally heavy cash payments are due and prorate such expenses over the entire year, to avoid distortion of expense in any single month in the expense budget. While this is the most desirable method, it is not always possible. The next best approach is to weight certain months over others where the expense of the

Exhibit 12—XYZ Hospital Budget Year Ending 19—
Supply Expense—Department of Anesthesiology

Part One

	Year Ending 5/31/53	Year Ending 5/31/54	Fiscal Year to Date	Estimate Ending 5/31/55	Estimate for Budget Year 19— to 19—	Estimated Cost per Month Budget Year 19— to 19—
Instruments	$ 335.00	$ 39.00	$ 31.00	$ 46.00	$ 60.00	$ 5.00
Anesthetics	7697.00	7811.00	6900.00	9640.00**	9000.00**	See Part Two*
Oxygen	5111.00	4969.00	3000.00	4059.00	4500.00	See Part Two*
Sundry	2739.00	3314.00	1856.00	2784.00	3000.00	250.00

*Estimated on cost per estimated patient days.
**Price increase expected
Cost per patient day—period ending fiscal year to date.
(a) patient days—60,000.
Anesthetics, fiscal year to date $6900 ÷ 60,000 = $0.12/pt. day
Oxygen, fiscal year to date $3000 ÷ 60,000 = $0.05/pt. day

Part Two

Month	Estimated Patient Days	SUPPLIES Anesthetics $0.12	SUPPLIES Oxygen $0.05
June, 19—	6720	$806.40	$336.00
July	6758	810.96	337.90
Total	83,044	$9,965.28	$4,152.20

item is greater as shown on an experience basis.

The third method, and by far the commonest because of relatively little effort involved, is to take the total estimate for each item of "other expense" and divide by 12. A management budget requires a combination of the three methods. Obviously, the first method of estimating the months in which the expense will occur is the best; however, since this is not always possible, a combination of methods must be used.

Other expense items may include:

1. Supplies
2. Miscellaneous
3. Repairs and maintenance
4. Social security
5. Annuity

Supplies Expense

Supplies are broken down by type for each department and as far as possible are based in units of measurement such as (1) estimated patient days, (2) births, and (3) number of operating procedures, and so forth. (See Exhibits 12, 13 and 14.)

(*Continued on Page* 140)

Exhibit 13—XYZ Hospital Budget Year Ending 19—
Supply Expense—Nursery

Part One

Supplies	Year Ending 5/31/53	Year Ending 5/31/54	Fiscal Year to Date	Cost per Pt. Day: Year Ending 5/31/53	Year Ending 5/31/54	Fiscal Year to Date	Estimated Budget Year 19— to 19—
Linen	$ 480.00	$ 909.00	$ 529.00	$0.06	$0.12	$0.10	$0.10
Sundry	1937.00	1213.00	924.00	0.24	0.16	0.18	0.18
Total	2417.00	2122.00	1453.00	0.30	0.28	0.28	0.28
*Patient days	7987	7554	5145				

*Average length of stay x total live births.

Part Two

Month	*Estimated Nursery Pt. Days Days—Budget Year	SUPPLIES Estimated Cost per Pt. Day: Linen $0.10	Sundry $0.18
June, 19—	665	$66.50	$119.70
July	670	67.00	120.60
Total	7935	$793.50	$1,428.30

*Based on past experience.

Exhibit 14—XYZ Hospital Budget Year Ending 19—
Supplies—Operating Room

Part One

Supplies	COST PER PROCEDURE*: Year Ending 5/31/53	Year Ending 5/31/54	Fiscal Year to Date	Estimated Budget Year 19— to 19—
Gauze, etc.	$1.95	$2.05	$1.95	$2.00
Drugs	0.55	0.65	0.60	0.60
Instruments	0.67	0.39	0.52	0.50
Sutures	1.69	1.96	2.00	2.00
Linen	0.62	0.67	0.69	0.70
Sundry	2.30	2.15	2.19	2.20

*Total cost—number of procedures.

Part Two

Month	*Estimated Number of Procedures	SUPPLIES Estimated Cost per Procedure: Gauze $2.00	Drugs $0.60	Inst. $0.50	Sutures $2.00	Linen $0.70	Sundry $2.20
June, 19—	560	$1,120.00	$ 336.00	$ 280.00	$1,120.00	$ 392.00	$1,232.00
July	540	1,080.00	324.00	270.00	1,080.00	378.00	1,188.00
Total	6,145	$12,290.00	$3,687.00	$3,072.50	$12,290.00	$4,301.50	$13,519.00

*Based on past experience.

Mental Hospitals Need Record Librarians

Good medical records make two useful contributions to mental hospitals: They help the hospitals obtain accreditation and add to the general knowledge of one of the greatest health problems—mental illness

ELEANOR F. CHRISTIAN, R.R.L.

WITHIN the last 10 years gentle stirrings have been heard within the walls of the nation's mental hospitals. From the concept of the custodial domicile, or "snake pit," has come the hospital of today, more nearly parallel to the general hospital and following in many respects its treatment program. Treatment, not only for the mental illness but for associated physical ills as well, has joined with treatment for the sociological maladjustment of the patient. Along with this concept have come the physician and surgeon, the radiologist and pathologist, the registered nurse, registered laboratory and x-ray technicians, electroencephalograph technicians, and, among others, the registered medical record librarian.

The medical record librarians who have entered this field have found a stirring challenge. Not only have they had to bring together a heterogeneous mass of information into an approved medical record, but they have had to do so, all too often, with the active opposition of the persons with whom they must work on a supervisory level. Fortunately this has not been the case with the administrative personnel, which has welcomed the medical record librarian and has put forth every effort to smooth the way for her acceptance.

The medical staff as a whole has accepted the medical record librarian and extended active cooperation. The older physicians, who have been in institutional service many years, have often been slow to accept but, once converted, have become the most enthusiastic backers of the medical records department.

Mrs. Christian is now on the staff of the 4167th U.S.A.F. Hospital, Travis Air Force Base, Calif. At the time this article was prepared, she was record librarian at Atascadero State Hospital, Atascadero, Calif.

RECORD PROCEDURES VARY

In the California mental hospitals much of the procedure has grown up over the years, and it is fascinating to see how, with the same base upon which to build, the inuividual hospitals have developed a different structure. In only two hospitals of the nine which I have visited were the medical record procedures almost identical; and it is of interest to note that, in these two, the medical record librarians were persons who had had much general hospital experience. In building their procedures they had not been in contact with each other, but had worked out procedures on the base suggested by the Sacramento office and their thinking had been almost identical. One record librarian had worked in an army hospital; the other in a large county hospital prior to entering state service.

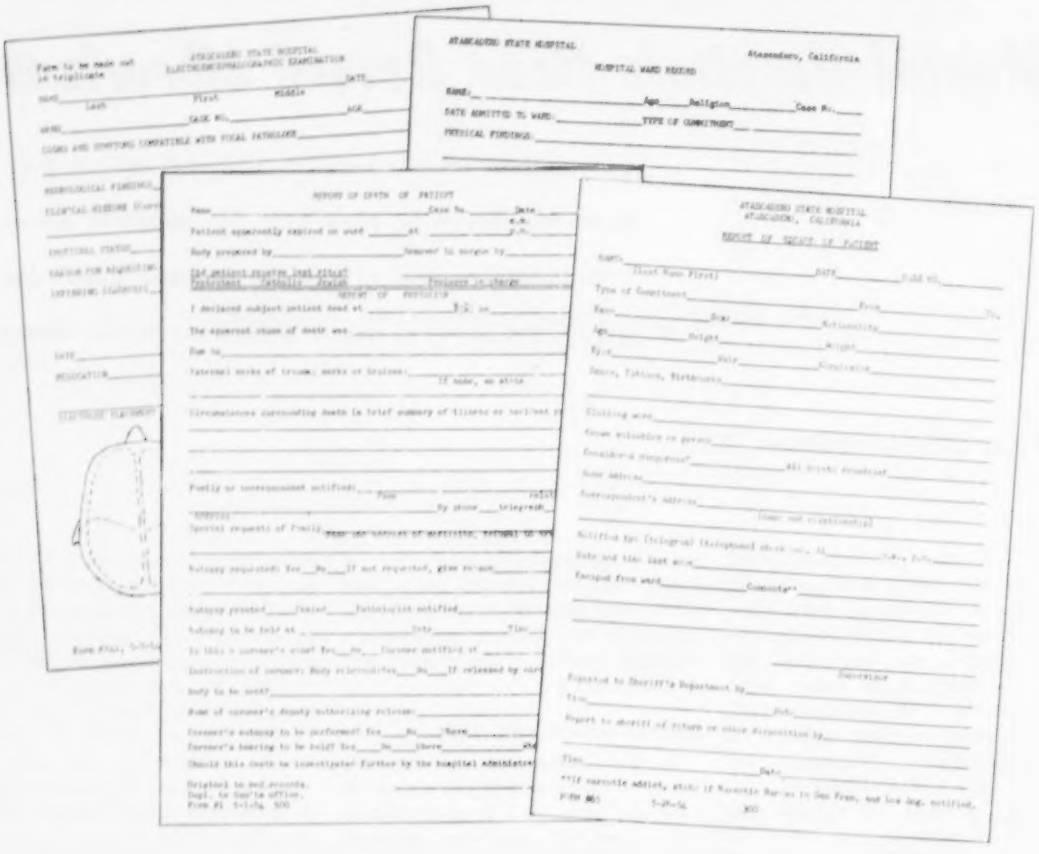
The Sacramento office is the guiding agency for the California state hospitals' medical records department, namely, the office of statistical research which assembles, collates and records information from all the state hospitals in the medical record field. This agency has been most helpful in the advice and counsel needed in setting up approved departments, as well as in the standardization of forms.

To the regular duties of the medical record librarian are added such duties as the superintendent of the individual hospital may require, and the setting up of such local data as may be needed by the local administration. For example, in one hospital the clerk who operates the duplicator is under the direction of the medical record librarian; in the next, under the administrative assistant; in the next, the business services. The teletype service is likewise in various departments: in personnel offices in one hospital; in medical records in the next; at the switchboard in the next, and in the superintendent's office in the fourth. In some hospitals, all stenographers are under the medical record librarian; in others, only the medical stenographers. Some departments handle the mail; others do not. And so it goes.

Even more than in the general hospital, the medical record librarian finds an interlocking and interweaving of departments. The elimination of one step without due questioning will sometimes compound the work of another department, and it is best to study the structure carefully before dropping a procedure. Then perhaps you will find that by adding one simple step you can help two or three departments. The question is not of seeking more clinical and statistical information, but primarily that of utilizing and coordinating that which is available, but has not been centralized.

The whole traditional structure brings to mind the incident of the ice. A nurse on one of the wards noticed that daily the ice cart would come to the back of the wards, and a large piece of ice would be deposited on the porch. This lay there all day and

SAMPLE RECORD FORMS USED AT ATASCADERO STATE HOSPITAL, ATASCADERO, CALIF.



all night until it melted away. She watched for a time; then she inquired. It seemed that about six months prior to her inquiry, the old ice refrigerators had been replaced by electric ones. No one had notified the ice department, so the ice was delivered daily as it had been for years. In such ways do customs build up like barnacles upon the hospital structure, and so do they remain.

The elimination of barnacles is but one step. The question of "why" we do this and that must be upon the new record librarian's lips constantly. If no one can tell her why, then perhaps the barnacle is not really needed. So we find that it is exceedingly important that we attend conferences with the heads of other departments. Here the "why" can often be answered, and we find that our supposed barnacle is not a barnacle at all but an essential part of the hospital structure.

The medical record itself becomes an interesting problem. This record may cover years for the chronically ill patient, or a matter of two to three days for the neurotic voluntary patient. It may be a knotty legal problem, or it may be a criminally insane patient's violent history. It is the sum of not just the physician's observation and treatment, plus laboratory reports, but a grouping of contacts with psychiatrists, psychologists, social service workers, rehabilitation therapist, and nursing personnel. So here again comes a relatively different concept of record keeping.

The general history of the patient in the mental hospital becomes the psychiatric examination. This is not limited to the mental examination alone, but combines physical, sociological and legal data as well. Well done, it is a work of art; and to the medical record librarian, a thing of real beauty. It is surprising how easily this may be obtained, when the psychiatrist is given proper assistance from the medical record department, and which the medical record librarian is trained to provide.

When the administration has set up an accepted form, outlines are furnished to all psychiatrists. Then comes the strategic placing of dictating equipment, so that the staff members may record their findings in the quiet of their offices, and transcription can be done in the medical record department without delay. The signing of the transcribed material is likewise easily achieved by the use of centralized "mail boxes" for each physician.

The department of mental hygiene has noted these factors and is most sympathetic to the purchase and use of good dictating equipment. The placing of the medical stenographic pool under the supervision of the medical record librarian, standard practice in the general hospital, has likewise been recognized as a factor in obtaining good medical records in the mental hospitals.

The patient's physical examination is recorded on two levels, the first a brief physical examination upon the admission of the patient, and the sec-

ond, a more complete examination by the assigned physician, ordinarily done within the first week of the patient's admission. This form is signed and placed in the patient's record, and its findings summarized into the psychiatric examination.

Laboratory forms are similar to those used in most general hospitals, *i.e.* the small reports to affix to a main sheet. Routine Kahn and urinalysis, as well as chest x-ray, tests are performed on admission. Should the examining physician feel that further tests are indicated, he is quick to order them as necessary.

X-rays are read by competent radiologists, usually on a consultant basis, and all types of x-ray services, save deep therapy, are available. X-ray reports are typed and distributed through the medical record department in the main, since the quantity of work in many of the hospitals does not justify a full-time stenographer-clerk in the x-ray department. The setting up of the x-ray diagnostic file has also devolved upon the medical record librarian, and has proved to be a simple matter by use of the standard outline form, which may be elaborated as much as desired by the individual hospital.

In some of the hospitals the record librarian encountered one of the strange situations which existed prior to her coming. The surgical service was well organized; the patients were receiving excellent care, but no basic data could be obtained as to the diagnosis, the type of illness, and the treatment given, other than by plowing through the entire record, and even then it was not clearly stated.

Here the approach by the librarians with general hospital experience was almost uniform. A hospital ward form was set up, and this served as a summary sheet when the patient was transferred back to his ward in the mental unit after a stay in the hospital unit. Working independently, Dorothy Shoemaker, R.R.L., at a hospital for the mentally retarded, set up a form which shows the diagnosis and the code number as well. Rose Kauffman, R.R.L., in a hospital for mentally ill and also tuberculous mentally ill, set up a simpler form of hospital ward report, which includes a brief summary of progress, as well as a summary of physical findings.

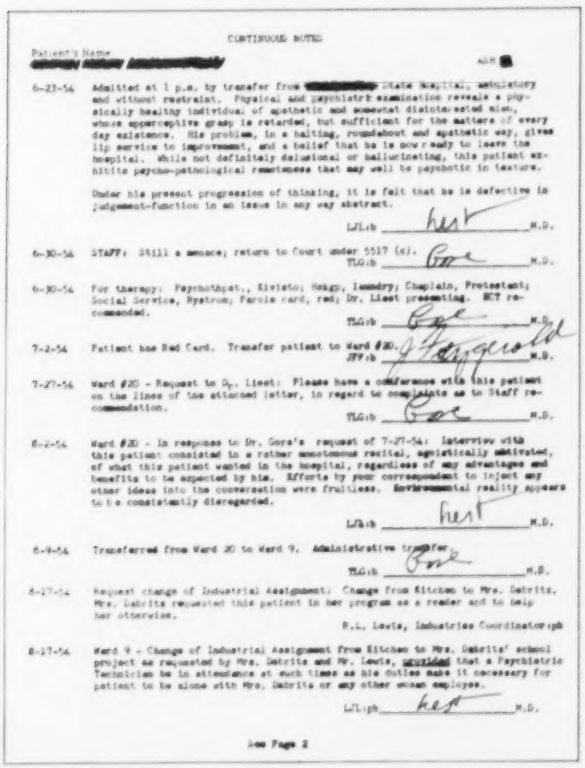
In the hospital for the mentally retarded, each illness is treated as a separate unit, the clinical charting being sent to the patient's folder with the summary as soon as he returns to his ward. A modification of this has the clinical charting continuous upon the ward, with the summary sheet alone being made a part of the patient's record. The object of this is to make a chronological study of the patient's course in the hospital rather than a series of isolated instances of illness, and would appear to have the additional merit of simplicity.

The continuous record, or progress sheet, as with the general hospital record, is one of the most important parts of the record. Here we have a true story of the care and treatment program of the hospital, as applied to the individual patient, and over a period of several months, sometimes years. Entries are made as change in the patient's status occurs, perhaps daily or weekly in the disturbed periods, and then less frequently as he stabilizes. The department of mental hygiene requires that the ward physician make a quarterly summary in the record of each patient on his service, and this serves the dual purpose of keeping the record current, as well as familiarizing the ward physician with patients on his service, many of whom may not have come to his attention by any specific need.

Here again one meets a problem peculiar to the mental hospital. In the general hospital the progress sheet is the province of the physician plus the house medical staff. In the mental hospital the progress of the patient is measured by his contacts with the various hospital agencies: the social service, rehabilitation and industrial therapists, recreational and music therapists, chaplains and school teachers. It does not seem too far afield to suggest, as I do, that these various therapists enter a progress note as to the patient's response to their particular program into the continuous record itself. If the staff members are trained and competent in their fields, they should summarize the patient's progress in their respective areas in simple terms, without infringing on the diagnostic and medical responsibility, as well as the legal responsibility, of the physician and the psychiatrist.

Statements as to the over-all progress of the patient, opinions as to his

CONTINUOUS RECORD, OR PROGRESS SHEET



CONTINUOUS NOTES

Patient's Name [redacted] ADM [redacted]

6-23-54 Admitted at 1 p.m. by transfer from [redacted] State Hospital, ambulatory and without restraint. Physical and psychiatric examination reveals a physically healthy individual of apathetic and somewhat disinterested elem., whose apperceptive grasp is retarded, but sufficient for the matters of every day existence. His problem, in a halting, roundabout and apathetic way, gives lip service to improvement, and a belief that he is now ready to leave the hospital. While not definitely delusional or hallucinating, this patient exhibits psycho-pathological remoteness that may well be psychotic in texture.

Under his present progression of thinking, it is felt that he is defective in judgement-function in an issue in any way abstract.

LJL:b [signature] M.D.

6-30-54 STAFF: Still a menace; return to Court under 5517 (a).

TLG:b [signature] M.D.

6-30-54 For therapy: Psychothpt., Rivlato; Hosp., Laundry; Chaplain, Protestant; Social Service, Bystrom; Parole card, red; Dr. Lieut presenting. ECT recommended.

TLG:b [signature] M.D.

7-2-54 Patient has Red Card. Transfer patient to Ward #20.

JFF:b [signature] M.D.

7-27-54 Ward #20 - Request to Dr. Lieut: Please have a conference with this patient on the lines of the attached letter, in regard to complaints as to Staff recommendation.

TLG:b [signature] M.D.

8-2-54 Ward #20 - In response to Dr. Gore's request of 7-27-54: Interview with this patient consisted in a rather monotonous recital, egotistically motivated, of what this patient wanted in the hospital, regardless of any advantages and benefits to be expected by him. Efforts by your correspondent to inject any other ideas into the conversation were fruitless. Environmental reality appears to be completely disregarded.

LJL:b [signature] M.D.

8-9-54 Transferred from Ward 20 to Ward 9. Administrative transfer.

TLG:b [signature] M.D.

8-17-54 Request change of Industrial Assignment: Change from Kitchen to Mrs. Debrita. Mrs. Debrita requested this patient in her program as a reader and to help her otherwise.

R.L. Lewis, Industries Coordinator:gb

8-17-54 Ward 9 - Change of Industrial Assignment from Kitchen to Mrs. Debrita' school project as requested by Mrs. Debrita and Mr. Lewis, provided that a Psychiatric Technician be in attendance at such times as his duties make it necessary for patient to be alone with Mrs. Debrita or any other woman employee.

LJL:gb [signature] M.D.

See Page 2

mental or physical health, should not be entered by ancillary personnel of any type. Too often have we met real problems in legal situations where ancillary workers have attempted to diagnose or institute therapy in direct contradiction to the statements of the medical, psychiatric or psychologic staff. Yet a short summary of their contact with the patient in respect to that particular area of his social contacts would be of great importance in the over-all story of the patient's progress, and should certainly appear in chronological sequence to be of greatest value.

QUARTERLY NOTES ENTERED

The approach to this problem has been to have quarterly notes entered after discussion with the psychiatric team, with oral reports on specific behavior made directly to the ward physician, who then incorporates all of these reports into his summary. That this is good, if the information is available to the physician at the time of his dictation, cannot be denied. There is, however, a great possibility of loss of valuable information where the ward physician is rushed for time and the department head is a little lax in reporting. Word-of-mouth reporting is always subject to pressure of time, loss of detail, and often to inability to summarize one's thoughts. A progress note that is written for eventual incorporation into the physician's summary is good, but then physicians have enough papers to read, and one can hardly visualize the reading of from three to six separate written reports on some hundred patients in order to get a picture of the patient's response to the ancillary treatment programs.

If we could incorporate these in chronological sequence into the continuous record, I do not believe they would need to be signed, since they would serve merely as signposts along the highway of progress rather than the full stop for a résumé of the patient's progress. I sincerely believe that with education of the ancillary personnel as to the type of information, and the care needed in the wording and preparation of these notes, we would receive excellent information as to the patient's day-to-day progress. This, then, is a matter for the medical record librarians, in conjunction with the hospital record committees, to consider well. We would not want the progress record to be "snowed under" with a mass of nonprofessional opinion, or half-page progress notes which mean nothing. Somewhere there must lie a happy medium, and it is for the departmental policy makers to tell us just where.

I have made no mention of the nursing service recording, since this is already obtained on forms of its own, and yields much valuable information. In fact, the nurses are the eyes and ears of the hospital and, as in the general hospital, the patient judges the hospital by those with whom he comes in daily contact. Never was this truer than in the mental hospital, where contact with the patient is 24 hours daily, and many times for months or years. I have nothing but respect for the technicians and aides in the mental hospital wards; they are good people, doing an excellent job, progressive, and willing to learn. The ward records are more and more approaching accreditation levels, and educational programs are making themselves felt in this respect.

REPORT TO OTHER AGENCIES

The preservation of the medical record in the mental hospital becomes one of prime importance. Though progress in treatment has been made, there are still relapses, and returns to other state hospitals, or even to correctional institutions. The problem of reporting on mental illness to other institutions and agencies becomes a great part of the work load of the medical record librarian, and quite a responsibility. California interpretation of the law is that the patient is competent until the courts have adjudged him otherwise; consequently we protect the confidential nature of the medical record as does any general hospital. We obtain the patient's signature for the release of information if he is at all competent to give this, or of the next of kin or guardian if the staff feels that he does not realize what he is signing.

Our position is somewhat more delicate than that of our sisters in the general hospital field in this respect. True, the patient has been on hospital service all the time, and we do not have to obtain the permission of his private physician, but then a diagnosis of mental illness has far-reaching social consequences, much more so than a diagnosis of acute appendicitis. The release of unauthorized information may lead to a diversion of patient's funds to others, a divorce, the removing of a child from his custody. It may lead to the loss of his position and his place in the community, since public acceptance of mental illness still lags behind the treatment program. The rule of thumb is: If it is a matter of public record, we may disclose it; otherwise we are guided by the ultimate good of the patient.

RECORDS SHOULD BE RETAINED

Since legal involvements cover many, many years, we must always keep the record as well as our commitment papers available. Microfilming is good, of course, but has its limits. My own opinion is that the record should be retained in its entirety as long as space permits. Should it become necessary to microfilm, the entire record should be filmed, including discharge and death certificates, and all correspondence. Twenty years would be my personal rule for microfilming. I know that I will get quite an argument on this, but I believe that hard experience will bear me out. Remember the political broadcast introduction which says that the opinions to be given are those of the individual and do not express the opinion of the agency sponsoring the broadcast? That statement applies here. It raises an interesting legal problem, too. Just what is the statute of limitations on a mental case record, involving as it does many and delicate legal situations? Attorneys, please answer!

To record librarians who say to me, "How can you work in a mental hospital! Don't you find it depressing?," I can truthfully answer, "On the contrary, I find it very stimulating."

We feel that the medical record librarian has much to offer the mental hospitals in that if the medical record reflects the tremendous effort which goes into the treatment program, it will not only be a prime factor in obtaining accreditation for the hospitals, but will add to knowledge of one of our nation's greatest health problems of today, mental illness. Both statistically and in terms of records, the medical record should meet the needs of our hospitals, not only for today, but for research into the health of society as a whole. Where else but in a mental hospital can we work to bring these things into focus, and learn a little bit about ourselves while we are doing it?

Equipment Room Has a Place for Everything

Akron City Hospital's central equipment room, a subdivision of central supply, combines the advantages of centralized and decentralized storage, with the added virtue of greater accessibility and convenience to the nursing personnel

JAMES W. COOKE

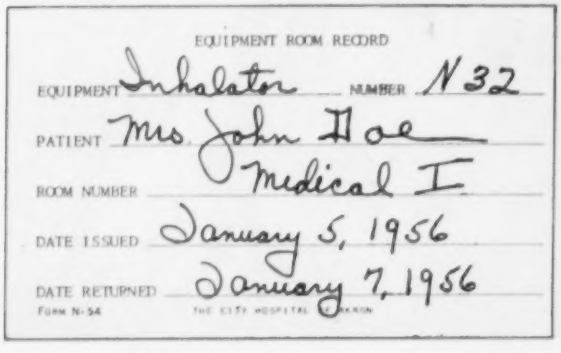
ALL hospitals, from the small 75 bed community hospital to the large 1000 bed metropolitan medical center, have to store, clean and maintain sufficient nursing equipment to meet the needs of adequate patient care. Every hospital administrator must decide just how these functions are to be carried out most efficiently. Individual nursing equipment items can be stored on every nursing unit, in central supply, or, as is more often the case, the equipment is stored on both the nursing units *and* in central supply.

If each nursing unit stores its own nursing equipment, then it is solely responsible for cleaning and maintaining this equipment. When the equipment is stored in this manner, it is both convenient and accessible to the nursing personnel of that unit, but the majority of nursing units do not have adequate storage space or personnel time to permit effectual supervision of the cleaning and maintenance of the equipment. It is also extremely difficult to keep track of equipment that may have been removed to another working area in which it was needed.

Since the responsibilities of the central supply department are primarily those of providing nursing units with clean equipment and sterile supplies for patient care, it is at once evident that the thorough cleaning and maintaining of all nursing equipment is most efficiently accomplished in that department. The storage problem in central supply, however, is not always less acute than that of the nursing

Mr. Cooke is administrative assistant at Akron City Hospital, Akron, Ohio.

A sample equipment room record card on which are recorded the name of the equipment, patient's name, room number, equipment number and date issued. When equipment is returned, card is pulled from file, and destroyed.


EQUIPMENT ROOM RECORD

EQUIPMENT Inhalator NUMBER N32

PATIENT Mrs. John Doe

ROOM NUMBER Medical I

DATE ISSUED January 5, 1956

DATE RETURNED January 7, 1956

Form N-54 THE CITY HOSPITAL AKRON

The supervisor of the central equipment room answers a call for equipment. When the room is unattended a recording device attached to the telephone takes all the messages so that there is no danger of a call's being missed.

units, depending upon the size of the department.

The numerous problems connected with the storage, cleaning, accessibility and maintenance of nursing equipment on the nursing units and in central supply prompted Akron City Hospital to explore the possibilities of creating a subdivision of the central supply department to be called the central equipment room.

All nursing equipment that was stored, cleaned or maintained in central supply, various nursing units, oxygen room, nursing office, emergency room, and storage closets was collected in one location, the purpose of which was to combine the advantages of both centralized and decentralized storage into an efficient central equipment room. The benefits to be derived from this new subdivision of central supply were better accessibility, convenience to nursing personnel, improved cleaning methods, adequate supervision over maintenance of equipment, better control over the location of equipment, and facilitation of a physical inventory.

The central supply department, which managed the majority of the nursing equipment, had quite inadequate storage space, and the problem was made more complex with the addition of 60 adult beds to the already existing 505 beds in the fall of 1954. Prior to the inauguration of the new equipment room several months ago, central supply, in most instances, stored, maintained and recorded the issuance of patient restraints, suction machines, inhalators, drainage bottles and other assorted nursing equipment. Central supply was, of course, performing all of the routine services customarily associated with such a department, and the added responsibility of storing most of our nursing equipment under the severe handicap of inadequate storage space was a burden to that department.

Another segment of the equipment storage problem was the inaccessibility of the central supply department. Central supply is located on the seventh floor of an eight-floor surgical building. Nurses, nurse's aides, and orderlies had to take at least two elevator trips and sometimes more to reach central supply.

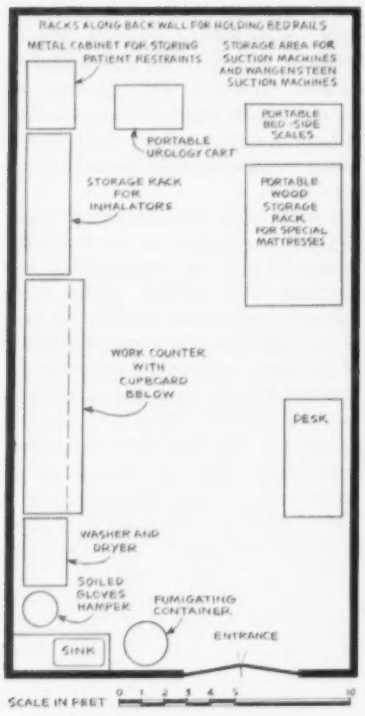
At times when a specific piece of patient equipment was needed for a nursing procedure, the attempt to locate it was a real problem, since several nursing stations had to be called to see if they had such a piece of equipment that was not in use. This was not the result of having too little nursing equipment, but of the inefficiency brought about by hunting for patient equipment throughout the entire institution.

Problems such as these cannot exist without great loss of personnel time, inconvenience to personnel, damage to expensive nursing equipment, and possible loss of efficiency in patient care.

Last spring, the assistant director of Akron City Hospital had the mail duplicating room moved from its centralized first floor location into the general offices of the hospital. Instituting this transfer, with a specific purpose in

Over-all view of the central equipment room, showing the disposition of the various articles. An advantage of the central room is that it permits of improved cleaning methods and adequate supervision of maintenance.

PLAN OF CENTRAL EQUIPMENT ROOM



Drawing showing the disposition of various articles in the central room.

A closeup of the portable wood storage racks for special mattresses. At the back of the room the carpenter built racks for the bed rails.

mind, made it possible to plan the central equipment room in this newly vacated space.

This spot had all the necessary requisites: central location, adequate space, built-in wall cabinets, adequate light and ventilation, and modest facilities for washing nursing equipment. A telephone was immediately installed and the records intended for use in an inventory system were printed in the hospital print shop. Plans for the central equipment room had previously been made, since this new service would have become a reality many months ago except for the lack of a suitable location.

The first step in getting the operation of the equipment room under way was to determine which assorted pieces of nursing equipment would be stored in the equipment room. The director of nursing service and the central supply supervisor were asked to compile a tentative list of all nursing equipment stored throughout the hospital which they thought should be stored in the equipment room. The number of suggested items to be stored increased daily until the list contained nearly 50 different items. Interest mounted in the new venture when it became evident that many equipment items that had not previously been returned to central supply were found in various parts of the hospital.

Everyone concerned with the new equipment room was fully aware of the importance of staffing it with a capable person. If this new venture was to be successful, a great deal would depend upon the ability of the person in charge of its daily functions. It was decided that a nurse's aide already employed in the central supply department would be the most logical choice, since she already possessed a working knowledge of the equipment and the hospital plant, and could be readily trained for the position. The central supply supervisor was asked to recommend an employe within her department for this position. Because the new equipment room would remove a tremendous work load from the central supply department, she was more than glad to staff the equipment room with one of her most capable nurse's aides.

It was decided that the equipment room would be staffed from 7 a.m. to 3:30 p.m., six days a week. After 3:30 p.m., the orderly staffing the oxygen room would take the calls in the equipment room for both equipment

AKRON CITY HOSPITAL
EQUIPMENT IN CENTRAL EQUIPMENT ROOM

Air freshener	Isolation equipment	Restraint strap
Alternating pressure mattress	Stands	Restraint cuffs
Commodes (low)	Hampers	Restraint keys
Communion set	Gown rack	Restraint blanket
Cradles	Iron lung equipment	Side rails
Deodorizing lights	Collars	Sphygmomanometer
Drainage racks	Pads	Stupe kettles
Eye instrument set	Perineal lamps	Canvas stretchers
Catheters	Patient roller	Suction machines
Hair drier	Portable bed scales	Spirometers
Heaters	Proctoscopes	Stop watch
Humidifier	Polio equipment	Thoracic pump
Inhalators	Large stupe pack	Urology cart
Insufflator	Polio foundation stupe	Wangensteens

and oxygen service. A telephone recording device was installed in the equipment room by the telephone company. Since this device records all phone messages, it enables the person on duty to be absent from the room without missing an important call. By utilizing the telephone recording device in the equipment room, there is 24 hour personnel coverage in this department.

One day prior to the opening of the new equipment room, the equipment that was previously stored in central supply was moved to the equipment room. When this task was completed, an immediate survey was made of all nursing units in an attempt to locate all nursing equipment that should no longer be stored on the nursing units. Even though it was thought that the compiled list of equipment items was nearly complete, new items were added because nursing personnel would question the practicality of storing infrequently used nursing equipment on the floors. For instance, all patient bed rails that were not in use were returned to the equipment room, leaving only one or two pairs on each floor for immediate use when necessary. During this relocation process it was ascertained that numerous pieces of nursing equipment needed prompt attention from the maintenance department; this was one immediate result of the consolidation process.

When all of the nursing equipment was finally relocated in the equipment room, every item was then tagged with an identifying number. Numbers were already on the suction machines, inhalators and other assorted pieces of equipment since this is a routine procedure at Akron City Hospital, but the bed rails and patient restraints had never been tagged. The leather restraints and other fabric items were marked with paint and the bed rails identified with metal tags. Since the department was going to be operated on a strict requisition basis, the numbering of each piece of equipment was mandatory. The equipment that was in use during this two-day relocation process was dismissed until it was returned to the equipment room, at which time it was also numbered.

After all of the equipment had been numbered or tagged it was placed on shelves or in cupboards. The bed rails were placed on wall racks made especially for this purpose in the carpenter shop. Restraints were hung in pairs in a previously discarded metal cabinet. The remainder of the equipment was either stored in the wooden cupboards or left standing on the floor.

Prior to the opening of the equipment room, nursing employes had to leave their respective nursing units and go to central supply or other nursing units to obtain this nursing equipment. It was evident that considerable personnel time could be saved by having one person, rather than many, making trips with nursing equipment throughout the hospital. Now when a call is received from one of the nursing units for a piece of nursing equipment, the nurse's aide or orderly on duty takes the equipment to the nursing station and completes the equipment room record with the help of the ward secretary. On the equipment room record are recorded the name of the equipment, patient's name, room number, equipment number, and date issued. The nurse's aide or orderly returns to the equipment room and files the equipment room record alphabetically in a card file. When the equipment is returned, the record card is pulled from the file and destroyed. The nursing equipment is cleaned and inspected prior to its return to storage. If some piece of equipment needs maintenance, a maintenance requisition is filled out by the equipment room personnel and forwarded to the maintenance department.

CHECKS DISCHARGE LIST

A list of patients that have been discharged from the hospital during the past 24 hours is compiled each midnight in the admissions office and distributed throughout the hospital by the nursing office the following morning. The nurse's aide on duty in the equipment room runs each discharged patient's name through the file of requisitioned nursing equipment to see if there is a piece of equipment remaining on one of the nursing units that is still assigned to a discharged patient. If there is no equipment room record in the active file, we are reasonably certain that if any equipment had been issued to that particular patient it has been returned to the equipment room prior to the date of discharge. If a card is found in the active file, the charge nurse on the respective patient's floor is called and requested to return the equipment to the equipment room.

There has been no unexpected controversy over this portion of the internal control system in the equipment room, a fact which is the result of education of the nursing personnel before the equipment room was initially put into actual operation. Memorandums were sent out to all nursing stations explaining the operation of the equipment room; it was presented at head nurses' meetings, and was discussed extensively with the nursing supervisors.

Shortly after the equipment room was put into operation, an automatic household type of washer-drier was installed. All surgical gloves were formerly washed and dried in the hospital laundry, and the controlled drying of the gloves presented a real problem. The laundry was spending as much as four hours each day drying surgical gloves, and then they were not entirely satisfactory. Now all surgical gloves are washed and dried in the equipment room. After the gloves are dried, they are sorted into sizes by the nurse's aide on duty in the equipment room. This eliminates one additional task formerly done by the personnel of central supply. The laundry is no longer burdened with this task and a much cleaner and drier surgical glove is obtained by this process.

Considerable thought and combined effort were put forth to institute the central equipment room at Akron City Hospital. The obvious need for this undertaking enhanced its chances for success. The numerous advantages of this venture are, in summary, the following:

1. Alleviation of the equipment storage problem on the nursing units and in central supply.
2. Nursing equipment more easily accessible to the majority of nursing units.
3. More efficient control over the distribution of nursing equipment to the various nursing units.
4. Equipment needed in an emergency situation readily located.
5. Facilitation of a physical inventory of nursing equipment.
6. Maintenance and replacement of worn and obsolete equipment readily accomplished.
7. Routine cleaning and maintenance of equipment as the direct responsibility of one person.
8. Greatly improved method of washing and drying surgical gloves.

The central equipment room was a new undertaking at Akron City Hospital several months ago. Now it is no longer an experiment but a tried and tested addition to our nursing service.

Charges Vary for Anesthesia, Recovery Room Services

Survey of 100 hospitals reveals that most large hospitals provide anesthesia and recovery room service but there is little uniformity in the charges made

LOUIS BLOCK, Dr. P.H.

LARGER hospitals today uniformly provide professional anesthesiology service and postoperative recovery room service, but there is little uniformity among hospitals charging for anesthesia materials and recovery room service, a recent survey of 100 hospitals revealed.

The survey was conducted by a market research organization maintaining a scientifically selected panel of hospitals from which data on purchasing and consumption are received regularly. Periodically, the panel hospitals are asked to submit special information relating to certain policies or services; the report on anesthesia service is based on one such survey.

Hospitals participating in the panel are all 100 beds or larger, it was reported.

Following are specific replies relating to questions on anesthesiology service, charges for anesthesia materials, recovery room service, and the charge for recovery room service.

Dr. Block is chief, Research Grants Branch, Division of Hospital and Medical Facilities of the U.S. Public Health Service, Washington, D.C.

ANESTHESIA SERVICE

1. Question

How many hospitals provide the services of a professional anesthesiologist?

Answer

(a) Better than 4 in 5 (85%) of the hospitals responding provided such a service.

(b) Almost 3 in 4 of the hospitals (73%) which did *not* provide such a service were under 250 beds in size.

2. Question

Do hospitals make a materials charge in addition to the anesthesiologist's service fee?

Answer

(a) Many of them do, but there appears to be no uniform policy as to charges by hospital size.

(b) Better than 2 in 5 of all the hospitals queried (43%) indicated that they made a special charge for materials.

(c) When reduced to the ratio of those hospitals providing professional anesthesiologists, it showed that 1 in 2 of such hospitals (51%) charged for anesthesia materials.

3. Question

When hospitals do make a charge for anesthesia material, how much do they charge?

Answer

(a) Two in 5 of the hospitals responding make such a charge.

(b) Almost 3 in 5 hospitals of those that do (58%) charge less than $5.

(c) One in 3 such hospitals (31%) charge from $5 to $10.

(d) One in 9 such hospitals (11%) charge more than $10.

(e) Almost 9 in 10 of the hospitals charging for anesthesia materials charge less than $10.

RECOVERY ROOM

1. Question

How many hospitals have available a postoperative recovery room?

Answer

Two hospitals in 3 (68%) of those responding provided such a service.

2. Question

In those hospitals providing a postoperative recovery room, what is the charge for this service?

Answer

(a) Better than 1 in 5 (22%) of the hospitals which provide a recovery room make a charge for such service.

(b) The maximum charge indicated was $10.

(c) Almost 4 in 5 such hospitals (78%) did not charge for this service directly.

(d) Most hospitals making a charge for recovery room had a variable price depending upon the amount of time the room was occupied, *i.e.* hours of use, or the accommodation status of the patient, *i.e.* private, semiprivate or ward.

Data and analysis supplied by Taylor, Harkins & Lea, Research in Medical Marketing, Philadelphia. Through the use of its national hospital panel (100 beds and over in size) the company obtains special information relating to certain policy actions in hospitals. Each study is a separate one. Four such studies are undertaken annually. Replies to queries are usually received from between 80 and 100 different hospitals.

Analysis of Patient Care Elements

Concluding the series of prototype studies of the administrative and professional activities and services provided by hospitals of various sizes, based on a survey of 162 Ohio institutions

LOUIS BLOCK, Dr. P.H.

THE search for more detailed information concerning hospital operation has revealed that guide lines are much more adaptable if they show a range or spread in the activities or services being performed. This indicates a limitation in the use of average figures for this purpose, as averages are composites of both highs and lows and are thus affected by the extremes. Much more useful information can be obtained from median and range distributions (Q_1-Q_3) which show the variations occurring within 50 per cent of the hospitals grouped around the median for the services being considered.

The reports of 162 general hospitals were studied on just such a basis. Median distributions were determined and quartiles were established for certain operating information. Wherever possible, medians and quartiles 1 and 3 limits are shown.

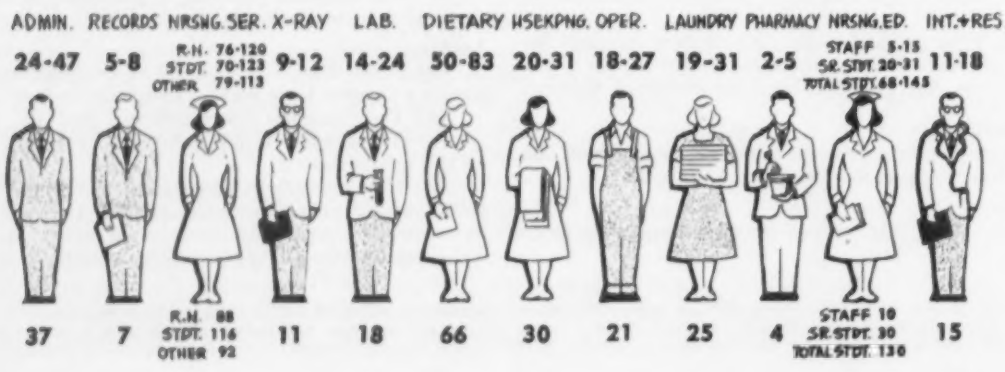
Dr. Block is chief, Research Grants Branch, Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C.

PART IX–250-299 BED GENERAL HOSPITALS

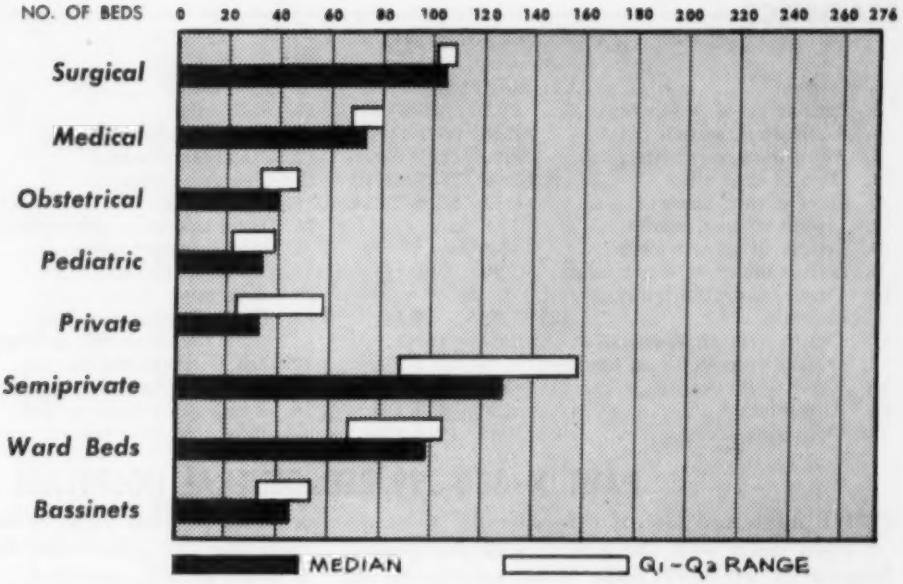
THE ninth of this series of presentations deals with the activities of the general hospital of 250 to 299 beds. When services do not occur in at least half of the hospitals within a particular size group they shall not be considered as being usually provided.

PERSONNEL DISTRIBUTION

Chart showing distribution of personnel in the general hospital of 250 to 299 beds. The median figure for all personnel (figures at bottom of chart) was 504, with a quartile range distribution (figures at top of chart) of 337-576. Personnel per patient (excluding interns, residents and students) was 2.23.



BED DISTRIBUTION



SERVICES

1.	Routine laboratory examinations	Yes	
2.	Routine chest x-ray on admission	No	
3.	Diagnostic x-ray service	Yes	
4.	Emergency service	Yes	
5.	Outpatient department	Yes	
6.	Nursing school	Yes	
7.	Whole blood	Yes	
8.	Plasma	Yes	
9.	Donor list for blood	Yes	
10.	Morgue	Yes	
11.	Superficial x-ray therapy	Yes	
12.	Deep x-ray therapy	Yes	
13.	Physical therapy service	Yes	
14.	Electrocardiograph service	Yes	
15.	Basal metabolism service	Yes	

PERSONNEL

1.	Medical record librarian	Yes	
2.	Interns	Yes	
3.	Residents	Yes	
4.	Student nurses	Yes	
5.	Roentgenologist on staff	Yes	
6.	Pathologist on staff	Yes	
7.	Internist on staff	Yes	
8.	Orthopedist on staff	Yes	
9.	Obstetrician on staff	Yes	
10.	Surgeon on staff	Yes	

X-RAY

		Median	*Q_1-Q_3 Range*
1.	Inpatient x-ray films	17988	10001-22169
2.	Total x-ray films	25436	17114-32067
3.	Inpatient fluoroscope examinations	1731	1099-2040
4.	Total fluoroscope examinations	1909	1587-2357
5.	Total x-ray examinations, inpatient	19039	12764-30985
6.	Total x-ray examinations	33464	16060-43915

LABORATORIES

1.	Inpatient bacteriological examinations	3524	1906-6491
2.	Total bacteriological examinations	4174	2274-6910
3.	Inpatient serological examinations	7499	4817-11739
4.	Total serological examinations	10130	6244-16015
5.	Inpatient blood chemistry examinations	7552	6199-13660
6.	Total blood chemistry examinations	8036	6610-14572
7.	Inpatient clinical blood examinations	47650	29265-50371
8.	Total clinical blood examinations	50386	31219-56592
9.	Inpatient clinical urine examinations	11273	10331-14695
10.	Total clinical urine examinations	11380	10488-15467
11.	Inpatient tissue examinations	4990	3464-6448
12.	Total tissue examinations	5223	4665-6823
13.	Inpatient other laboratory examinations	2833	1419-11603
14.	Total other laboratory examinations	3633	1423-12351
15.	Total inpatient laboratory examinations	89393	64869-107589
16.	Total laboratory examinations	101729	77762-118966
17.	Inpatient laboratory examinations per admission	9.3	——
18.	Units of whole blood on hand	50	35-60
19.	Units of plasma on hand	18	9-23
20.	Major source of blood supply	Red Cross	
21.	Secondary source of blood supply	Donors	

STATISTICS

	Median	Q_1-Q_3 Range
1. Census	226.3	199.6-241.7
2. Percentage of occupancy	83.5	72.3-87.6
3. Admissions, adult	10526	9671-11166
4. Admissions, newborn	2080	1821-2809
5. Days of care, adult	82598	72845-88210
6. Days of care, newborn	12231	8628-17028
7. Length of stay, adults	7.8 days	
8. Length of stay, newborn	5.4 days	
9. Deaths under 48 hours, adult	90	83-113
10. Deaths under 48 hours, newborn	28	25-34
11. Deaths over 48 hours, adult	204	162-210
12. Deaths over 48 hours, newborn	5	1-7
13. Total adult deaths	298	265-340
14. Autopsies	156	112-178
15. Deliveries	2045	1924-2793
16. Live births	2042	1895-2825
17. Stillbirths	38	16-41
18. Neonatal deaths	34	17-44
19. Maternal deaths	0	0-1
20. Cesarean deliveries	64	62-102
21. Prematures	122	105-158
22. Total operative deliveries	1418	1170-2026
23. Inpatient operations	5276	4608-6325
24. Total operations	6141	4665-7212
25. Emergency visits	5329	2466-9494
26. Physical therapy visits (of those that have this service)	7411	4117-10017
27. E.K.G. examinations (of those that have this service)	1749	1071-2337
28. B.M.R. examinations (of those that have this service)	385	262-480

PART X–300-399 BED GENERAL HOSPITALS

THE tenth and last of this series of presentations deals with the activities of the general hospital of 300 to 399 beds. When services do not occur in at least half of the hospitals within a particular size group they shall not be considered as being usually provided.

SERVICES

1. Routine laboratory examinations	Yes	9. Donor list for blood	Yes
2. Routine chest x-ray on admission	No	10. Morgue	Yes
3. Diagnostic x-ray service	Yes	11. Superficial x-ray therapy	Yes
4. Emergency service	Yes	12. Deep x-ray therapy	Yes
5. Outpatient department	Yes	13. Physical therapy service	Yes
6. Nursing school	Yes	14. Electrocardiograph service	Yes
7. Whole blood	Yes	15. Basal metabolism service	Yes
8. Plasma	Yes		

PERSONNEL

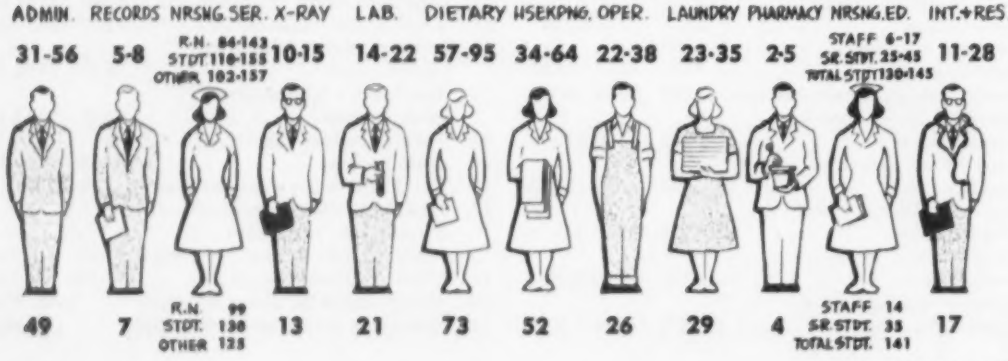
1. Medical record librarian	Yes	6. Pathologist on staff	Yes
2. Interns	Yes	7. Internist on staff	Yes
3. Residents	Yes	8. Orthopedist on staff	Yes
4. Student nurses	Yes	9. Obstetrician on staff	Yes
5. Roentgenologist on staff	Yes	10. Surgeon on staff	Yes

X-RAY

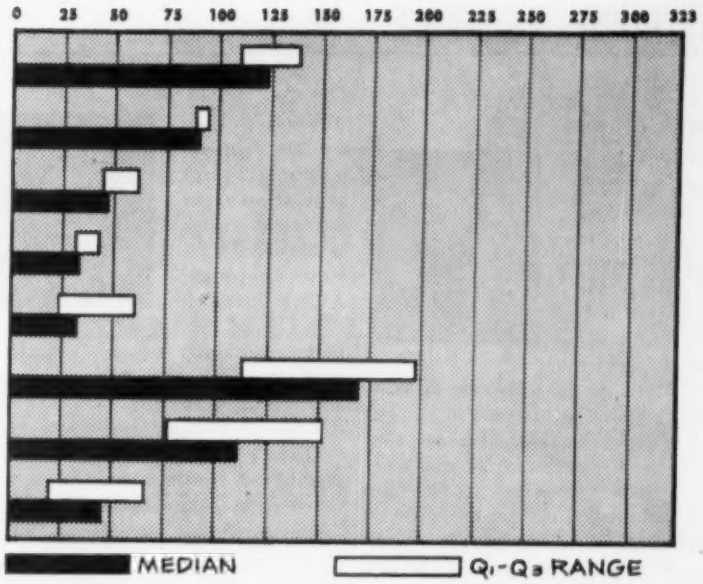
	Median	Q_1-Q_3 Range		Median	Q_1-Q_3 Range
1. Inpatient x-ray films	18162	13699-19498	4. Total fluoroscope examinations	2318	1245-2836
2. Total x-ray films	27478	18486-29967	5. Total x-ray examinations, inpatient	21031	14293-23186
3. Inpatient fluoroscope examinations	1887	1116-2228	6. Total x-ray examinations	34661	17929-35147

PERSONNEL DISTRIBUTION

Chart showing distribution of personnel in the general hospital of from 300-399 beds. The median figure for all personnel (figures at bottom of chart) was 520, with a quartile range distribution (figures at top) of 393-685. Personnel per patient (excluding interns, students, residents) averaged 1.92.



BED DISTRIBUTION



LABORATORIES

	Median	Q_1-Q_3 Range
1. Inpatient bacteriological examinations	4405	2067-5325
2. Total bacteriological examinations	4705	2311-8906
3. Inpatient serological examinations	10302	5470-13036
4. Total serological examinations	10552	7747-15417
5. Inpatient blood chemistry examinations	9928	6438-16475
6. Total blood chemistry examinations	10153	7099-17692
7. Inpatient clinical blood examinations	50153	33842-56929
8. Total clinical blood examinations	56483	36100-66927
9. Inpatient clinical urine examinations	13636	11134-16186
10. Total clinical urine examinations	15112	11707-35021
11. Inpatient tissue examinations	6540	3682-11001
12. Total tissue examinations	7119	5724-11192
13. Inpatient other laboratory examinations	3989	2260-12195
14. Total other laboratory examinations	4270	1528-7012
15. Total inpatient laboratory examinations	111704	78824-127123
16. Total laboratory examinations	115379	88025-141869
17. Inpatient laboratory examinations per admission	9.4	——
18. Units of whole blood on hand	60	40-90
19. Units of plasma on hand	22	20-36
20. Major source of blood supply	Red Cross	
21. Secondary source of blood supply	Donors	

STATISTICS

	Median	Q_1-Q_3 Range
1. Census	271.4	243.0-290.7
2. Percentage of occupancy	84.0	75.2-90.0
3. Admissions, adult	12051	9480-13653
4. Admissions, newborn	2703	2151-2852
5. Days of care, adult	99063	88696-106110
6. Days of care, newborn	14089	10086-16244
7. Length of stay, adults	8.2 days	
8. Length of stay, newborn	5.2 days	
9. Deaths under 48 hours, adult	101	66-123
10. Deaths under 48 hours, newborn	29	0-44
11. Deaths over 48 hours, adult	237	211-258
12. Deaths over 48 hours, newborn	6	0-12
13. Total adult deaths	336	308-358
14. Autopsies	186	114-203
15. Deliveries	2603	1703-2809
16. Live births	2580	1697-2796
17. Stillbirths	40	15-50
18. Neonatal deaths	40	11-57
19. Maternal deaths	0	0-0
20. Cesarean deliveries	78	62-118
21. Prematures	150	133-226
22. Total operative deliveries	1737	1430-2026
23. Inpatient operations	6101	4530-6771
24. Total operations	6599	4684-7891
25. Emergency visits	8363	6646-10240
26. Physical therapy visits (of those that have this service)	8358	5504-9617
27. E.K.G. examinations (of those that have this service)	2051	1358-2618
28. B.M.R. examinations (of those that have this service)	408	262-505

This is the last of a series of studies by Dr. Block analyzing services in these hospitals.

ABOUT PEOPLE

Administrators


Dr. H. M. Coon

Dr. Harold M. Coon has been appointed administrator of Milwaukee County Hospitals, Milwaukee, effective September 1. Dr. Coon is now superintendent of the University of Wisconsin hospitals at Madison, a position he has held since 1941. He has also served as superintendent of the Wisconsin State Sanatorium at Statesan, Wis., and medical director of the River Pines Sanatorium at Stevens Point, Wis. Dr. Coon, a past president of the Wisconsin Hospital Association, received the association's annual award for outstanding achievement in hospital administration last year. He is a fellow of the American College of Hospital Administrators. Dr. Coon will succeed **Dr. Harry W. Sargeant,** who will retire in January.

Harold H. Hixson has been named administrator of hospitals at the University of California Medical Center, San Francisco, and **Jerome M. Yalon** has been appointed associate administrator there. Mr. Hixson, formerly associate administrator, is responsible for the operation of the 500 bed Moffitt Hospital and the 300 bed University Hospital. He succeeds the late **William B. Hall,** whose death is reported elsewhere in these columns.

Dr. Edward H. Leveroos has assumed the duties of director of the Ochsner Foundation Hospital, New Orleans. Dr. Leveroos formerly was director of the division of hospitals and graduate education of the A.M.A.'s Council on Medical Education and Hospitals. In his new position, Dr. Leveroos succeeds **Dr. Lester L. Wiessmiller,** who resigned to accept a position with the Veterans Administration.

William A. Markey has assumed the duties of assistant administrator of the City of Hope Medical Center, Duarte, Calif. Prior to his new appointment, Mr. Markey was director of the outpatient department at Montefiore Hospital, Pittsburgh. He is a graduate of Yale University's course in hospital administration and served his residency at Beth Israel Hospital, Boston.


James T. Farley

James T. Farley has been appointed assistant general manager for special studies at Memorial Center for Cancer and Allied Diseases, New York. Mr. Farley will direct a newly organized methods improvement program in all areas of the center. He was formerly director of methods improvement at St. Luke's Hospital, Chicago. He is a graduate of Northwestern University's course in hospital administration.

Neil C. Wortley has been appointed hospital administrative consultant with the Missouri State Health Department in connection with the new state hospital licensing law. Mr. Wortley, formerly administrator of Burge Hospital, Springfield, Mo., is a graduate of Washington University's course in hospital administration and a member of the American College of Hospital Administrators. **Elmer W. Paul** has assumed the duties of administrator of Burge Hospital. Mr. Paul, prior to his appointment, served as administrator of Methodist Hospital, Lubbock, Tex.

Al Donnell has been named administrator of the Muskogee General Hospital, Muskogee, Okla. Mr. Donnell is the former administrator of McAlester General Hospital, McAlester, Okla. A graduate of Northwestern University's course in hospital administration, he will succeed **David Huffman,** who will be associated with Ross Garrett, a hospital consultant in Houston, Tex.


M. S. Grobsmith

Michael S. Grobsmith has been appointed executive director of the Jewish Convalescent Hospital of Cleveland, a new 330 bed chronic care facility to be established. Mr. Grobsmith was formerly administrator of the building program for the Hadassah Medical Organization—Hebrew Medical School in Jerusalem, Israel. He has also served as executive director of Miriam Hospital, Providence, R.I., and assistant director at Lebanon Hospital, New York. Mr. Grobsmith is a member of the American College of Hospital Administrators.


Col. F. H. Gibbs

Col. Frederick H. Gibbs, director of the department of administration at the Army Medical Service School, Fort Sam Houston, Tex., has been appointed director of the Interagency Institutes for Federal Hospital Administrators at Walter Reed Army Medical Center in Washington, D.C. Col. Gibbs organized the hospital management research and improvement program for the army surgeon general during an assignment in Washington, from 1948 to 1952. At that time he was executive officer of the Medical Plans and Operations Division and chief of the Management Research and Planning Branch for the surgeon general. **Col. William A. Hamrick** will succeed Col. Gibbs as director of the department of administration at the Army Medical Service School. Before going to the school as an advanced student, he was in the office of the Secretary of Defense.

James M. Kittleman has been named director of resources and development for Presbyterian-St. Luke's Hospital, Chicago. He is a licensed architect and engineer. **Norman A. Brady** has been appointed as one of the two assistant directors of the combined hospitals. Mr. Brady, at present assistant director at Presbyterian, is the former manager of Sunnybrook Hospital, Toronto, Ont., and Queen Mary Veterans Hospital, Montreal, Que. **John A. Holbrook** has been named executive engineer.


D. L. Odell

David L. Odell has assumed the duties of assistant director of the 2600 bed Rancho Los Amigos Hospital, a division of the Los Angeles County Department of Charities. Mr. Odell was formerly assistant administrator of the Methodist Hospital of Southern California, Arcadia. He is a graduate of the University of Minnesota's course in hospital administration.

Walter F. Preset is the new administrator of Methodist Hospital and Home for Aged, Pittsburgh.

(*Continued on Page* 172)

Does your staff have the right I.V. solution available for each patient's needs?

Specific fluid and electrolyte losses are now easily determined with modern tests like the flame photometer for potassium and sodium levels. As more is learned about fluid/electrolyte balance, a greater range of I.V. solutions is needed at the hospitals.

Cutter meets these needs with a complete line of special and standard electrolyte and nutrient solutions. Below are a few typical cases of how Cutter meets specific needs of each patient.†

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† The complete line of Cutter Special and Standard Electrolyte Solutions and Additives, arranged in a convenient mEq table, is available upon request.

Abstracted Case Histories

Case 1 – Male, 24 years. Condition: Herniotomy. Therapy: Prevent acidosis and restore electrolyte balance with postoperative use of Cutter Poylsal®.

Case 2 – Female, 53 years. Condition: Resection of sigmoid carcinoma with ileostomy. Therapy: Correct acidosis, prevent hypopotassemia and maintain daily body requirements of electrolytes, carbohydrates and water with Cutter Polysal-M.

Case 3 – Male, 42 years. Condition: Alkalosis following pyloric gastric obstruction and gastric drainage. Therapy: Combat alkalosis with Cutter Invert Sugar 10% in Electrolyte Solution No. 3 (Cooke and Crowley's Gastric Solution).

Case 4 – Female, 27 years. Condition: Diabetic acidosis. Therapy: Alkalyze and stabilize with Cutter Polysal and then follow with Cutter Invert Sugar 10% in Electrolyte Solution No. 2 (Butler's Formula).

Case 5 – Male, 54 years. Diagnosis: Postoperative small bowel obstruction with drainage by Miller-Abbot tube. Therapy: Replacement of daily fluid and electrolyte losses with Cutter Invert Sugar 10% in Electrolyte Solution No. 1.

Case 6 – Female, 31 years. Condition: Severe diabetic coma. Therapy: Initial treatment with Cutter M/6 Sodium Lactate Solution.

Case 7 – Male, 42 years. Diagnosis: Gastric carcinoma. Therapy: Combat protein deficiency with Cutter C.P.H.* (5% Protein Hydrolysate in 5% Dextrose Solution).

Case 8 – Female, 1 year, 2 months. Diagnosis: Irritative diarrhea with hypopotassemia. Therapy: Restore fluid and electrolyte balance with Cutter KNL® (Darrow's Solution).

*TM

VOLUNTEER FORUM

Who Wants What Type of Accommodation?

The need for flexibility in the physical layout of hospitals is indicated by studies of patients' views on the type of accommodations they prefer

ISADORE ROSENFIELD and ZACHARY ROSENFIELD

THE idea of semiprivate accommodations dates back only to the period following World War I. Before that the choice was generally between private accommodations or an open ward. Today the semiprivate room is the predominant unit of accommodation in voluntary general hospitals. Indeed, hospitals built since World War II in some economically and socially homogeneous communities have semiprivate accommodations exclusively. The open ward is hardly ever to be seen in new planning and in its place we have the four-bed room.

The fact that times and attitudes change indicates that it is desirable to have flexible physical arrangements. At this time such flexibility is not available at a reasonable price, but it is hoped that under the current congressional $1.2 million appropriation for hospital research an economical system for shifting partitions could be developed. In the meantime, hospitals in the plan stage *have* to decide on the distribution of accommodations and, subject to flexibility to be derived from the use of semiprivate room as a private one, the physical arrangements have to be fixed more or less for good. To make structural and mechanical changes (in terms of present technology) afterward is extremely costly. Consequently, we must plan reasonably flexibly and as accurately as possible.

The usual "method" of arriving at the ratio between private, semiprivate and multibed rooms is to listen to someone who appears to have authority. In the case of a new hospital, it is frequently a committee of doctors, the consultant, or the architect, or someone of the board who seems to have "the right idea." Some people follow a formula the validity of which is elusive. Others consult the experience of near-by hospitals and such a method has validity if the economic and cultural character of the communities being consulted happens to be similar to the community in which the hospital is being planned.[1]

In case of expansion or replacement of an existing hospital, the previous experience of that hospital is usually taken as the guide. This in turn has its limitations because a hospital seeking expansion or replacement is usually hopelessly overcrowded. Under such circumstances, the sick have no choice and are obliged to accept what is available instead of what they really can afford or desire.

It is not intended here to convey the idea that we have found the solution to the problem. In the face of shifting socio-economic conditions, there is no perfect solution. We may not even be sure how long the whole concept of the currently conventional three-category system will last, since it has come into usage during the last three decades.

In England, for instance, where, admittedly, the socio-economic circumstances are quite different from ours, a recent Nuffield Fund report came to the conclusion that the best nursing unit arrangement[2] is a grouping of six-bed and four-bed alcoves comprising 16 beds plus four beds (25 per cent of the congregate beds) in single rooms. Lords and commoners would occupy the beds without distinction. The single rooms would be for those needing them on a medical-administrative basis but could be had as "private rooms" in our sense only if not needed by someone on a medical-administrative basis. Apparently in England the intention is at this time that a person should go to a hospital primarily to get well. Privacy appears not to be an issue. In our case the problem of getting well has been inexorably tied in with privacy of various and sundry degrees and that, of course, is one of the large factors which makes hospital construction and operation so costly.

Some hospital authorities have questioned the validity of the very concept of "semiprivacy" saying that it is like "semipregnancy" and, concomitantly, there has been a considerable drive for a preponderance of private accommodations in new planning.

In a recent experience involving doubling the capacity of a hospital[3] the question of how to apportion the types of accommodations was solved

The authors are architects-hospital consultants, New York City.

[1] For other aspects of the problem of apportioning accommodations, see Rosenfield, Isadore: How Many Private Beds? Hosp. Prog. 33:50 and 33:45 (January and February) 1952.

[2] Studies in the Functions and Design of Hospitals, Oxford University Press, London, New York, Toronto.

[3] The Palo Alto-Stanford University Hospital, Palo Alto, Calif. The authors and Rex W. Allen were the consultants.

EXISTING AND PREFERRED DISTRIBUTION OF BEDS BY TYPE OF ACCOMMODATIONS

Type of Accommodation	Medical-Surgical			Maternity			
	Current Distb.	Disregarding Price	Higher Prices	Current Prices	Disregarding Price	Higher Prices	Current Prices
Private rooms	15.6%	24.6%	8.3%	11.2%	12.2%	2.2%	2.1%
Two-bed rooms	53.7%	52.3%	36.1%	54.5%	63.3%	44.5%	57.5%
Four-bed rooms	30.7%	15.4%	38.3%	27.6%	8.2%	24.4%	23.4%
Wards		7.7%	17.3%	6.7%	16.3%	28.9%	17.0%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

in a rather unusual manner. The community consisted largely of suburban, middle-income, professional people in the presence of a substantial university population and its influences The administrator of the hospital had a fair idea of how the beds were to be apportioned, but he preferred not to make this planning decision. Instead he proposed a questionnaire to be put to all the patients in the hospital for a period of two weeks.

The questionnaire was arranged on three price levels:

1. The current price schedule.
2. What the patient would like if he could pay, no matter what the cost.
3. What he would want if the price of each category of accommodation were raised $2 per day above the present rate.

The tabulated result compared with the existing distribution of the accommodations was somewhat startling. It seemed unbelievable and for that reason it was decided after a lapse of several weeks to distribute the questionnaire again for another period of two weeks. The second batch of answers was so nearly identical with the first that it was decided to accept both sets as the verdict of the patients.

The accompanying table shows the answers compiled and compared with the existing physical distribution of accommodations. Inasmuch as the origin of each answered questionnaire was marked, it occurred to us to separate the maternity patients from the general medical-surgical category. This made the contrasts even more marked and brought out the fact that the attitude of maternity patients is different from the others.

The following conclusions suggest themselves:

Regardless of Price

1. Advocates of a "private room for everybody" particularly will be disappointed to learn that purely on a "like and dislike" basis and regardless of economic consideration, only about 25 per cent of patients (other than maternity) would care to be in a private room. This is strikingly like the conclusion arrived at in the English study.

2. Only 50 per cent prefer what we may refer to as the "American standard" or semiprivate accommodations regardless of price.

3. About 23 per cent would like to be in a congregate room even if they could afford private accommodations.

At Prices Current in the Hospital

1. Perceptibly fewer people would occupy private rooms than now do. Apparently, about 28 per cent of those who currently occupy private rooms do so not because they can afford them, but because they have no choice because of overcrowded conditions in the less expensive categories.

2. Corollary to the foregoing, more people would prefer to be in semiprivate rooms than there are of such rooms. The same applies to multibed facilities; 34.3 per cent of the patients would prefer multiple bed rooms when only 30.7 per cent of such beds exist in that category.

At an Increase of $2 per Day per Bed in All Categories

1. Only 8.3 per cent of the patients would want private rooms against a supply of 15.6 per cent. This means that 46 per cent of the present component of private rooms would stand idle; 33 per cent of the existing semiprivate rooms would also stand unoccupied, and 55.6 per cent of the patients would wish to occupy multibed accommodations of which only 30.7 per cent are available.

Maternity Beds

As planners we have been inclined to regard maternity patients as different only in point of clinical differentiation. It has not occurred to us before that maternity patients have an economic point of view which is different from other categories of patients. Here we observe that:

1. Maternity patients care little about having a private room, even at existing prices.

2. Maternity patients overwhelmingly favor semiprivate accommodations over the other types under all price conditions.

3. Many more favor multibed accommodations than do other patients.

The general attitude of maternity patients seems to be explainable as follows:

Who has babies?—Young people.

Who does not have money?—Young people.

Who needs money to care for newly arrived members of the family?—Young people.

We may be mistaken, however, by concluding that the differentiation in preferences is as between maternity cases and all others. Perhaps the significant factor is not childbirth, but youth in general. Perhaps the modern young person, male *and* female, feels differently about choice of accommodation than his elders do. If that is so, a new pattern is in the making that those who plan had better consider. But before jumping to conclusions, it would be well to study the problem in these categories: maternity patients, young nonmaternity patients, and older nonmaternity cases.

Insured vs. *Uninsured*

We then wondered whether the insurance status of the patient had any bearing on the patients' inclinations to choice of accommodations. We therefore reworked the above table on that basis as, fortunately, a question on the insurance status had been included in the questionnaire.

Medical-Surgical Patients

At current costs the insured general medical-surgical patients showed a barely perceptible preference for private and semiprivate accommodations as against four-bed rooms and wards, whereas the uninsured showed a marked preference for private beds over the insured. Perhaps the conservatism of the insured stems from their feeling of security and satisfaction with their status.

At higher prices, the insured shift perceptibly from private rooms to the

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preference for two-bed rooms, but still a goodly portion continues to have an appetite for private rooms.

When price is no consideration, the insured show a marked shift to the private room from multiple bed accommodations, the demand for semiprivate accommodations remaining about constant. The uninsured appear to be willing even to abandon the semiprivate room for the private if they did not have to be concerned about the bill.

Maternity Patients

Uninsured maternity patients show no desire for private rooms at current prices and some marked preferences for lower cost accommodations as compared with the insured.

At higher prices the insured maternity patients show a marked shift to lower priced accommodations, but the uninsured show an even higher shift in preference in that direction. In fact, not a single uninsured patient signified a desire for a private room in these circumstances. If money were no object, the insured maternity patients could not be lured from their preferences while the uninsured would shift preceptibly to private rooms.

In justice, however, it should be stated that many of the patients failed to indicate their insurance status. This resulted in low numbers to deal with, particularly as the insured far outnumbered the uninsured.

It may be said, therefore, that it would be sound public policy for hospitals to provide accommodations in keeping with the public's desires. These desires appear to be different as between the general medical-surgical categories and maternity patients. Further differences appear depending on whether the patients are insured or uninsured.

Whether the foregoing observations are reliable, since they are based on admissions of only four weeks' duration in a general hospital of about 200 beds, can be seriously questioned. Not only should the period of study be greatly extended, but more and more such studies should be made. In this connection, it is gratifying to note that one of the research projects approved by the federal authorities under the current research appropriation is for "a study of the influence of prepaid insurance for medical care on the utilization of hospitals and all hospital costs."[4]

[4]Health Insurance Plan of Greater New York.

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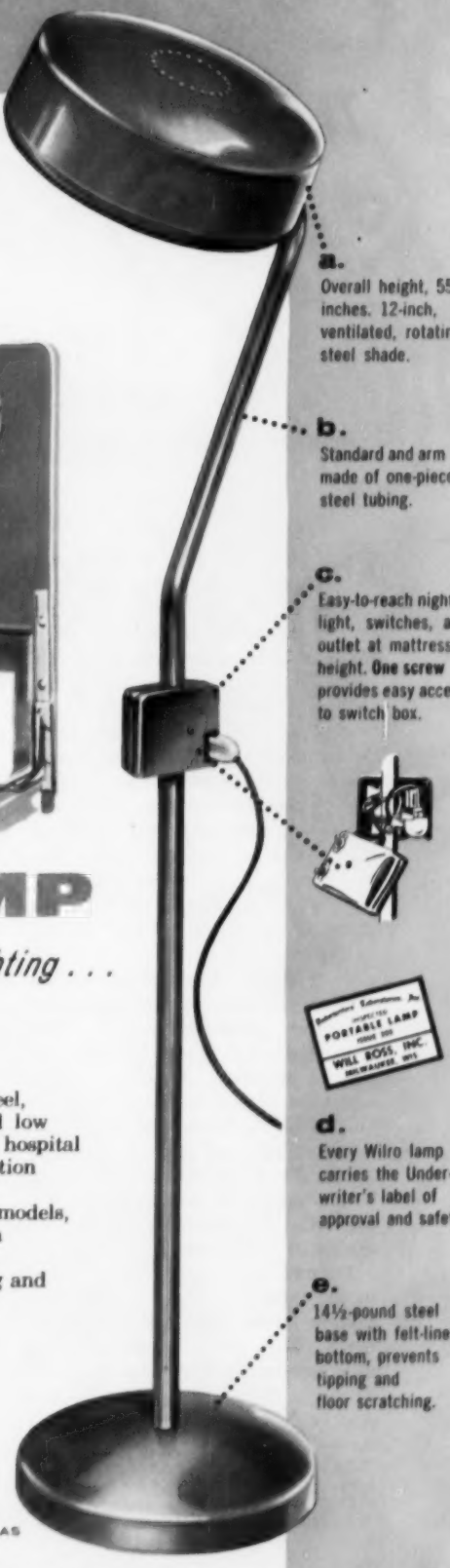

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ROBERT S. MYERS, M.D.

DURING the last 40 years the science of medicine has made astonishing progress in the diagnosis and treatment of illness, but there has been little, if any, concurrent advance in methods for evaluating the quality of patient care. Thus, the medical profession as a whole is in the anomalous and unscientific position of not being able to assess intelligently the effects of the potent and often dangerous tools with which it effects such miraculous cures. The simple truth of the matter is that we, as a profession, really know very little about the results of our care of hospital patients.

This is not an indictment of the medical profession which, more than any other profession, business, trade or occupation, is devoted to the welfare of mankind. Rather, it is an admission of the failure of those in medical administration to keep pace with the advances made by those in research and clinical medicine. We have not provided the means by which practicing physicians can evaluate the quality of patient care.

Doctors have always been interested in the reasons for their successes and failures in the treatment of their patients. With commendable frankness they recount their experiences abundantly in the medical literature. But not fully appreciated is the vast amount of time and effort expended year in and year out by the medical profession to evaluate the daily care of hospital patients. Unfortunately, much of this is wasted effort. In the first place, many of the usual indexes of adequate patient care are outmoded, unscientific and illogical.

Consider the normal tissue rate of 10 to 15 per cent for all normal tissues as the upper limit of justified surgery. This mythical rate, which is used in some hospitals as a measuring stick, disregards the evident fact that clinical indications for surgery, and not the tissue diagnosis made by the pathologist, justifies surgery in the individual case.

"DEATH RATE" IS MEANINGLESS

Again, a net death rate of less than 4 per cent and a postoperative death rate of less than 1 per cent are routinely accepted as evidences of adequate patient care. But we obtain a meaningless net death rate by dividing all deaths over 48 hours by the total number of discharges. Why 48 hours? Why not 12 hours, or why not all deaths occurring after the patient is admitted to the hospital? We delude ourselves with a 1 per cent postoperative death rate, for this is obtained by dividing all deaths within 10 days of operation by the total number of operations.

It makes little sense to divide deaths following operations for brain tumors and abdominal malignancies by dental extractions, hemorrhoidectomies and other operations from which the patient should recover. Moreover, why limit postoperative death to 10 days following operation? Medical science has advanced to the stage where life may now be prolonged for long periods after admission, or operation, and all deaths should be evaluated in any statistical method. Furthermore, deaths should be calculated in relation to a specific disease or operation. To do less is to foster rates which are no index of adequate patient care.

We set a top limit of 3 to 4 per cent for cesarean sections and view with alarm any increase over this figure. Yet a review of the literature and inspection of cases from reliable and recognized obstetrical centers show that, with justification, the rate now may be approaching 6 to 7 per cent. Cesarean sections are intended to facilitate the welfare of both the mother and the baby. Should we not be interested in knowing how many infants do not survive because the cesarean was too long delayed or because it was not done at all? We must revise our estimation of the justified cesarean section rate.

We speak of a rate of 1 per cent as the upper limit of justified postoperative infection and then are gratified that we have no infections, or very few at most, to report. It is true that modern medical science has means of preventing or reducing infection, but infections still occur after operation. With the use of antibiotics, justified in some cases and

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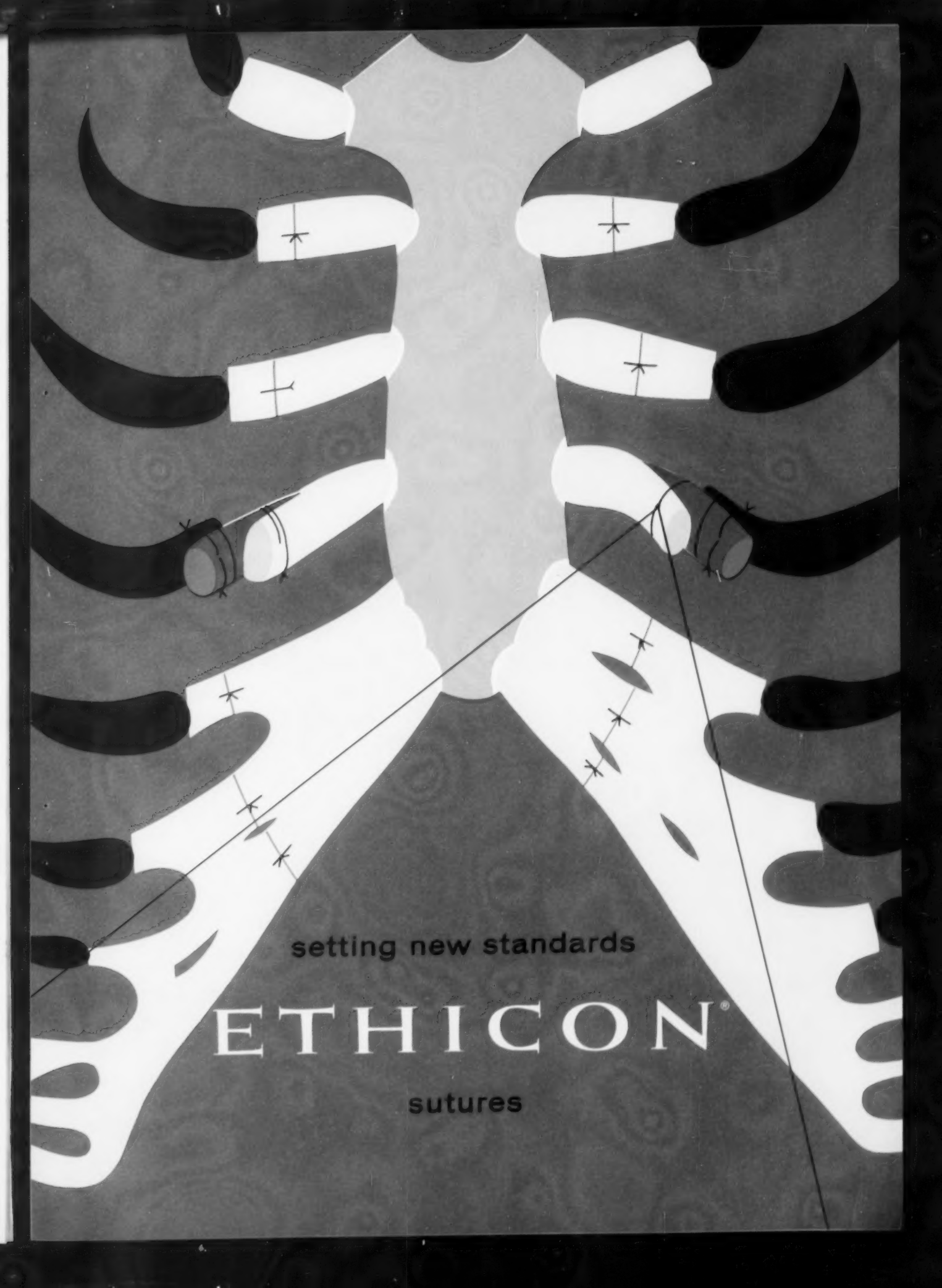
Presented before the Academy of Medicine of Cleveland, May 1956.

Dr. Myers is assistant director of the American College of Surgeons.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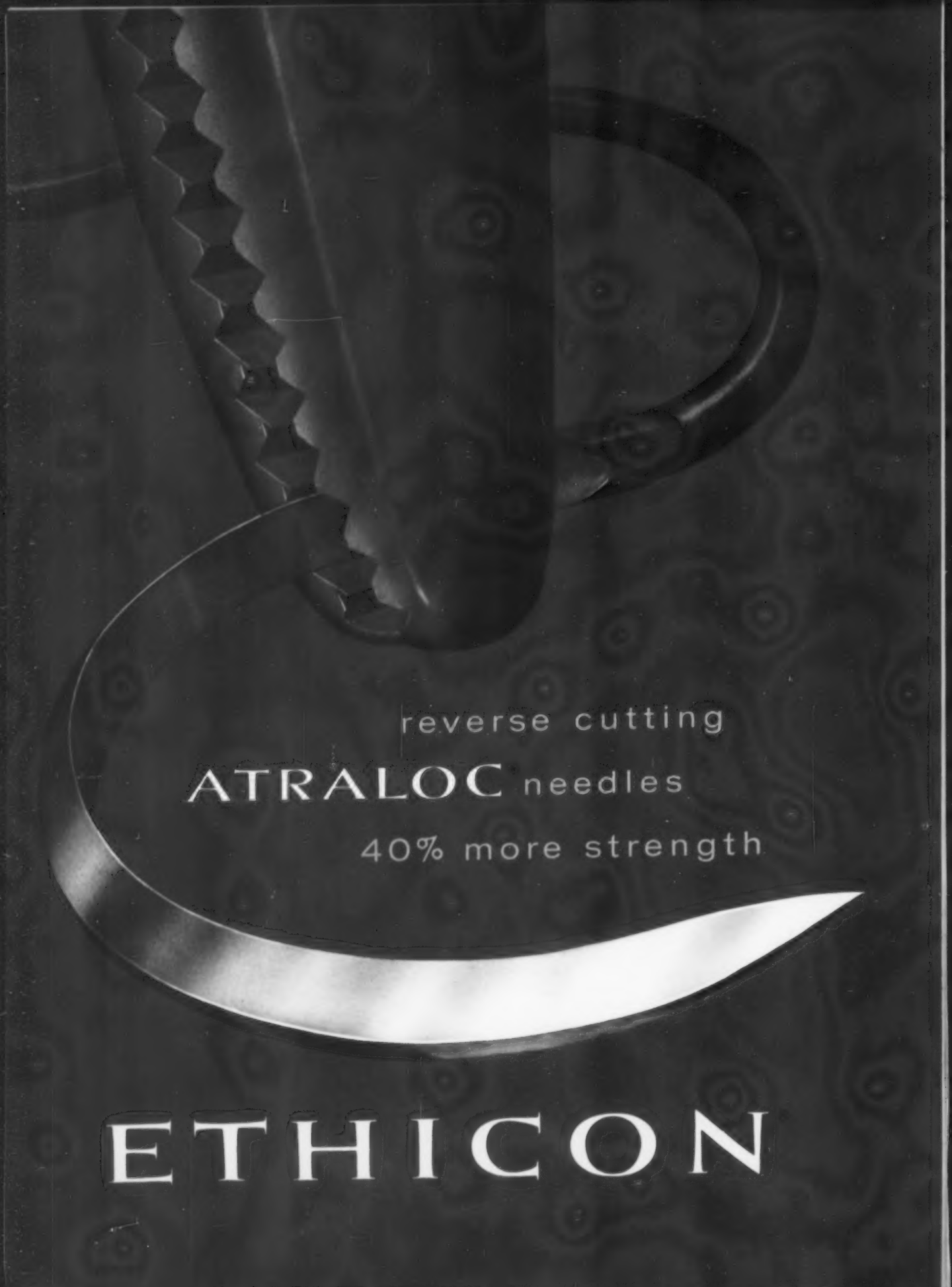
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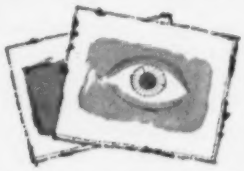

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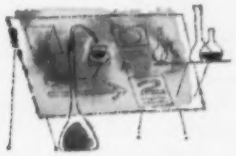

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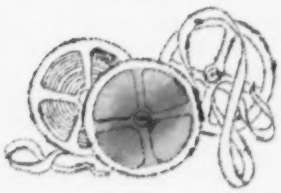

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indiscriminately used in many others, combined with the use of early ambulation, the patient now leaves the hospital early and may well develop his wound infection at home. Such infections are rarely reported back to the hospital record.

And as a final illustration of the prevailing confused thinking in the field of patient care evaluation, let me remind you of the common practice of using the terms "recovered" or "improved" or "unimproved" to describe the discharge status of patients. The use of these terms is not logical. In the first place, the "condition on discharge" is based on an impression of the status of a convalescent patient, and insufficient time has elapsed to permit evaluation of his treatment and condition. It is not known whether he is "recovered" or "improved" or "unimproved" at the time of discharge.

PER CENT OF PATIENTS WHO WERE REPORTED TO HAVE RECOVERED, BY HOSPITAL AND PHYSICIAN, 1953

Fig. 1: Percentage of "Recovered" Patients

Second, few patients seem to leave a hospital "unimproved." This could be a tribute to the care given by the medical profession and our hospitals, but is probably chargeable to the vagaries of human nature. It is more popular to have an "improved" patient. Actually, a patient leaves a hospital in one of two ways, alive or dead. Any other classification is sheer whimsy.

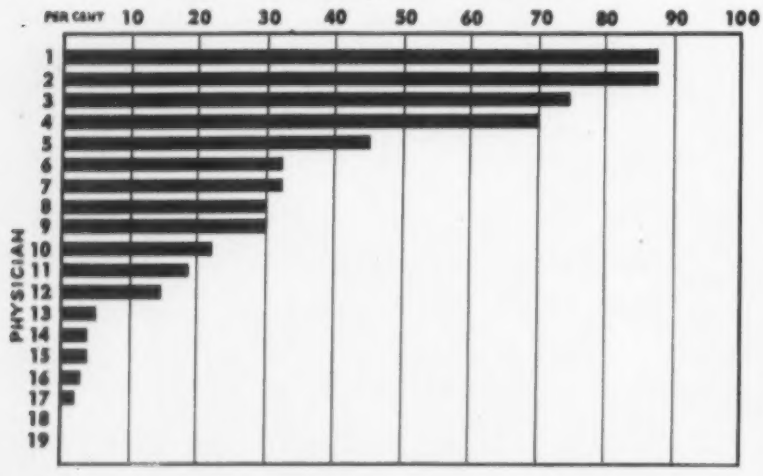
Figure 1 illustrates the extraordinary differences that exist in the percentage of patients who were discharged as "recovered" in 14 hospitals which are cooperating in a study of hospital statistics.

If one were to accept these statistics at face value, he would much prefer to be a patient in Hospital No. 1 with a 92 per cent "recovery rate" rather than Hospital No. 14 with a poor showing of 28 per cent "recovered." However, the patient would still have to take his chances with the individual doctors of any particular hospital in this group of hospitals.

Figure 2 shows the variation in the percentage of "recovered" patients among the 19 physicians of Hospital No. 13 in Figure 1. Two physicians were curing almost 90 per cent of their patients as contrasted with two other physicians who were curing none. Obviously, the term "recovered" is highly unreliable as an indication of the adequacy of patient care.

As a second illustration of the limitations of the usual evaluation of patient care, one must realize that the customary criteria of adequate care do not include all of the significant aspects of such care. The justification for surgery, the assessment of technic, the presence or absence of complications, important as each of these may be, do not include any mention of utilization of laboratory and x-ray diagnostic facilities, no evaluation of the hospital stay, and no assessment of the administration of drugs or treatments.

Fig. 2: Patients Reported as "Recovered"



In the third place, the type of evaluation that is customarily done by the medical records committees of medical staffs attempts to evaluate the record of every patient discharged from the hospital for every month. This puts an impracticable burden upon busy physicians, and the result is an inadequate evaluation poorly done.

Fourth, the prevailing practice of hand tabulation of criticisms of patient care wastes the time of physicians in a project which is more efficiently done by machine methods.

In view of these four basic deficiencies of current methods of patient care evaluation, it is small wonder that there is such a meager return of information from such a substantial investment of physicians' time and energy. It is also not strange that only a handful of hospitals has seen fit to use such methods to evaluate the quality of care.

What, then, is the solution of this dilemma of the medical profession? It is quite simple and consists of a practicable method of evaluation known as the medical audit[1] as developed by the American College of Surgeons during the last three years in cooperation with the Commission on Professional and Hospital Activities.[2] This particular method of the medical audit consists of two parts: (1) a statistical analysis of every record of every patient discharged from the hospital, which provides routine hospital statistics, medical record room indexes, and analyses comparing the practices and experiences of all participating hospitals and physicians; and (2) an evaluation of selected records by the medical staff, which permits an effective and timesaving spot check by physicians.

Further features of this method are (1) the factor of comparison between

(*Text Continued on Page* 102)

[1]Supported by grants from the W. K. Kellogg Foundation.

[2]The Commission is sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the Southwestern Michigan Hospital Association. The Commission is subsidized by the W. K. Kellogg Foundation and has established headquarters at Ann Arbor, Mich.

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SOUTHWESTERN MICHIGAN HOSPITAL COUNCIL
MEDICAL QUALITY CONTROL STUDY ** BATCH_____ PAGE_____

HOSPITAL	DATE OF DISCHARGE	ADMISSION NUMBER	ADMISSION EVALUATION		DEFICIENCIES NOTED	
1.	2. Month Yr.	3. THIS ADMISSION / UNIT NUMBER	Admission Was: 0. Elective 1. Emergency — 4.	Was Admission Properly Classified? 0. Yes 1. No — 5.	TYPE 0. None 1. Recording 2. Investigation 3. Diagnosis, Completeness 4. Diagnosis, Final 5. Treatment 6. Technique 7. Judgment 8. Combination 1 to 7 — 6.a	DUE TO 1. Physician 2. Surgeon 3. X-Ray 4. Laboratory 5. Hospital, Other 6. Patient 7. Other — 6.b

Diagnosis Causing Admission* 9a • Second Diagnosis* 9b • Third Diagnosis* 9c

EVALUATION BY DIAGNOSIS	9a Yes	9a No	9b Yes	9b No	9c Yes	9c No
9-1. Was History Adequate?						
9-2. Was Physical Adequate?						
9-3. Were Progress Notes Adequate?						
THERAPY EVALUATION 7. Code	A		B		C	
9-4. Was Basic Plan of Therapy Acceptable?						
8. Code	A		B		C	

INVESTIGATION	Adequate	Excessive	Insufficient	Inappropriate - Not Justified or Improper	CODE
12. Laboratory Studies Were					
13. X-Ray Studies Were					
14. Special Studies Were					

CONSULTATIONS
Were Proper Consultations Recorded? 1. Yes 2. No — 10.

COMPLICATIONS
0. None 1. Justified 2. Not Justified (Preventable) — 11.

DEATH EVALUATION
JUSTIFICATION: 1. Justified 2. 3. 4. 5. 6. 7. 8. 9. Not Justified (Preventable). (Committee Opinion Required for Other Than Justified Deaths.) — 16.a
TYPE: 1. Operative–Surgery 2. Operative–Anesthesia 3. Post-operative–Surgery 4. Post-operative–Anesthesia 5. Maternal, Operative–Surgery 6. Maternal, Operative–Anesthesia 7. Maternal, Post-operative–Surgery 8. Maternal, Post-operative–Anesthesia 9. Maternal, Other X. Other — 16.b

First Operation° 15a – Second Operation° 15b –

OPERATION EVALUATION	15a Yes	15a No	15b Yes	15b No
15-1. Did Pre-operative and Tissue Diagnoses Agree?				
15-2. Did Final and Tissue Diagnoses Agree?				
15-3. Did Pre-operative and Final Diagnoses Agree?				
17. Code	A		B	
15-4. Anesthesia—Were Type and Dose OK?				
18. Code	A		B	
15-5. Was Operation Justified?				
19. Code	A		B	

RECORD CONTAINS 0. Yes 1. No
Pelvic 20. Rectal 21. Blood Pressure 22.

HOSPITAL STAY
0. Adequate 1. Insufficient 2. Excessive 3. Inappropriate – Not Justified or Improper — 23.a
(If Too Long or Too Short, Indicate Responsibility) 1. Physician 2. Surgeon 3. X-Ray 4. Laboratory 5. Operating Room 6. Social Circumstances 7. Patient Request 8. Combination — 23.b

GENERAL MANAGEMENT OF CASE
1. Superior, 2. 3. Good, 4. 5. 6. Fair, 7. 8. 9. Poor (Any Grade Below 3. Requires Committee Opinion.) — 25.

NUMBER OF COMMITTEE MEMBERS REVIEWING THIS CASE — 26.
NUMBER OF MAN-MINUTES SPENT ON THIS CASE REVIEW — 27.
COMMITTEE DECISION NOT UNANIMOUS — 28.
REPORT COMPLETED BY (Enter Printed Initials) _____ — 29.

24. TREATMENT OR DRUG EVALUATION

	Therapy NOT Given: Improperly Omitted	Therapy NOT Given: Properly	THERAPY GIVEN: Properly	IMPROPERLY: Too Much	Too Little	Not Appropriate	Contra-Indicated	CODE
1. Chemotherapeutics and Antibiotics								
2. Narcotics								
3. Sedatives								
4. Blood, Plasma, Blood Vol. Expanders								
5. Fluids, Electrolytes								
6. Biologics – Oxytocics								
7. Autonomic N. S. Regulators–Antiallergics								
8. Anticoagulants—Antianemics								
9. Cardiac Regulators—Diuretics								
10. Endocrines, Steroids, Hormones								
11. Diet, Vitamins, Nutrients								
12. Physiotherapy, Ambulation, Rest								
13. Psychotherapy								
SPECIAL 14.								
SPECIAL 15.								
SPECIAL 16.								
SPECIAL 17.								

REMARKS:

FOR SPECIAL STUDIES 30.

* CODED BY STANDARD NOMENCLATURE
° CODED BY INTERNATIONAL CODE

Form No. SWMHC-120—9-54

Fig. 3: Audit Check Sheet Devised by the Commission on Professional and Hospital Activities, Ann Arbor, Mich.

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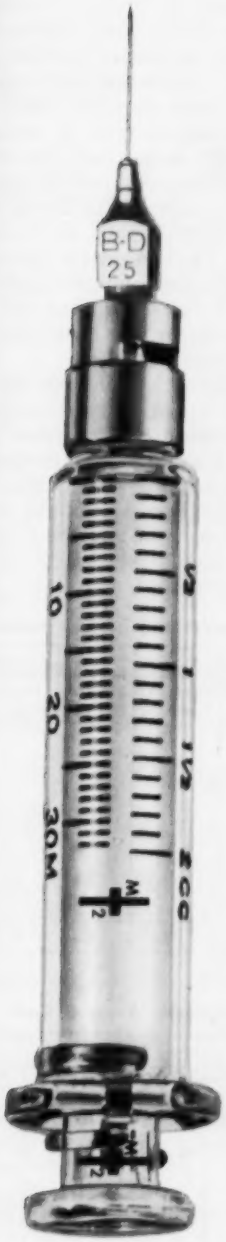

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(*Continued From Page 98*)
hospitals in order to discover differences in patterns of medical care for the same conditions, thus stimulating both the correction of existing deficiencies and also the adoption of more efficacious methods of patient care; (2) the limitation of the evaluation during a particular time period to a single category of disease or operation; (3) the inclusion of all pertinent criteria of adequate patient care in the evaluation, and (4) the use of modern business machines to tabulate, correlate, and analyze the recorded opinions of the physicians. Figure 3 (*p.* 100) shows the type of audit check sheet which we have devised to meet the foregoing requirements.

It is readily apparent that this audit check sheet permits the evaluating physician to record opinions about the adequacy of the three essential aspects of hospital patient care: hospitalization, investigation and treatment.

Hospitalization has three significant aspects: (1) the necessity for admission, (2) the promptness of admission to the hospital, and (3) the adequacy of the length of the stay of the individual. Each may affect the quality of care; and evaluation of these three facets should not only reveal the deficiencies of hospitalization, but should also demonstrate whether the responsibility for such inadequacies lies with the medical profession, the hospital or the patient.

Investigation encompasses the diagnostic work-up of the patient necessary to establish a definitive diagnosis in order to institute treatment. The term, as used in our audit method, includes the history, physical examination, consultation, laboratory, x-ray and other diagnostic aids. Each of these aspects must be assessed individually so that particular deficiencies may be revealed and corrected.

Treatment describes what was done for the patient and the results of such care. There are certain aspects of treatment and its results which are common to all diseases, medical and surgical: medications and other therapy, complications and deaths.

Following completion, the forms are sent to a statistical service center maintained in Ann Arbor, Mich., by the Commission on Professional and Hospital Activities, where the data are processed by machine, after which the results are returned to the hospital for the information of the medical staff and the hospital administrator. To illustrate the type of information obtained by use of the College's medical audit method, let us review a few aspects of the experience of a group of 20 typical community hospitals which recently completed the evaluation of 643 patients who were discharged from these hospitals during the period July to December 1954, with a primary or secondary diagnosis of disease of the gall bladder. This series of 643 patients is composed of 302 patients who were not submitted to surgery and 341 who had surgery.

Table 1 shows the criticisms of the length of hospital stay of this group of 643 patients. Of particular interest is the fact that 32 patients (64 per cent of the total of 50 criticized) were judged to have had too short a hospital stay and the patient was responsible for this insufficient stay in 17, or 53 per cent, of these cases. On the other hand, 13 patients (26 per cent of the total) were thought to have stayed too long; and the physician or surgeon was responsible for the excessive stay in eight, or 61 per cent, of these cases. Two of the excessive stays and two of the insufficient stays were judged to be due to "social circumstances," which is our designation for conditions in the patient's home or environment which adversely affect hospital stay.

Table 2 shows the deficiencies noted for particular areas of care of the patient. It is of no surprise that most of the deficiencies fall in the field of investigation which includes the recording of the history and physical examination, as well as the use of x-ray, laboratory, and other diagnostic aids. It is of interest, however, that of the 94 criticisms of the investigation, 15, or 16 per cent, were due to other than the physician or surgeon. These include deficiencies ascribed to the laboratory and hospital and to the patient for failure to cooperate.

Table 3 affords a more detailed account of the deficiencies of the recording of the history, physical examination, and progress notes. It is obvious that the number of deficiencies increases with the multiplicity of diagnoses made. This probably means that the physicians writing the records were primarily concerned with recording the details of the patient's chief complaint and neglected to give all pertinent features of the other disease conditions present. Of particular interest is the frequent criticism of re-

Table 1—Criticisms of Length of Hospital Stay of 643 Patients

Responsibility	Excessive		Insufficient		Inappropriate		Total
	Medical Patients	Surgical Patients	Medical Patients	Surgical Patients	Medical Patients	Surgical Patients	
Physician	5	1	11		1		19*
Surgeon	1	1					2
X-ray	1						1
Laboratory			1				1
Social Circumstances		2	2				4
Patient Request	1		16	1			19*
Combination		1					1
Not Stated			1		2		3
Total	8	5	31	1	3	0	50*

* Includes chart with criticism not stated.

Table 2—Deficiencies Noted for Particular Areas of Care

Type of Deficiency	Deficiencies Due to:														Total
	Physician		Surgeon		Laboratory		Hospital, Other		Patient		Other		Not Stated		
	M*	S*	M	S	M	S	M	S	M	S	M	S	M	S	
Investigation	37	25	1	14		1	1	4	5	4	1			1	94
Diagnosis, Final	8	3		1							1				13
Treatment	1	1		1					3						6
Technique		2													2
Judgment	3			1										1	5
Total Charts	49	31	1	17	0	1	1	4	8	4	2	0	0	2	120

*M = Medical; S = Surgical.

corded progress notes in the medical records. This indicates that physicians place considerable value on the progress note as a means of following the course of the patient's illness and treatment. It is our experience that there is a considerable misconception among the medical profession as to the necessary frequency and content of progress notes. The College of Surgeons used to recommend that a progress note be written at least every 48 hours on the patient's record when the College conducted the program of hospital standardization. This was a silly requirement, for reason would indicate that progress notes should be written as frequently as the patient's condition demands. This may be hourly in the seriously ill patient; it may be only a discharge note on the patient who had an uneventful convalescence and a short stay.

Table 3—Evaluation of Diagnosis, Gall Bladder Audit

Evaluation	Medical Patients		Surgical Patients		Total	
	First Diagnosis	Three Diagnoses	First Diagnosis	Three Diagnoses	First Diagnosis	Three Diagnoses
History inadequate	13	33	11	17	24	50
Physical inadequate	11	15	18	23	29	38
Progress notes inadequate	34	53	30	38	64	91
History and physical inadequate	6	13	8	13	14	26
History and progress notes inadequate	7	24	5	7	12	31
Physical and progress notes inadequate	7	7	6	7	13	14
History, physical and progress notes inadequate	23	36	9	14	32	50
Total inadequacies	101	181	87	119	188	300

Table 4—Incomplete Charts, Gall Bladder Audit

Not Recorded on Chart	Hospital																Total
	1	2	4	5	6	7	8	9	10	12	14	16	17	18	19	20	
Pelvic		2		5	4	1	1	2	1		1	1	1	2	3	8	32
Rectal	10	7		14	1	1	8	4	10	4	5	4	7	2	6	5	88
Blood Pressure	4	2				3	1			1					2		13
Pelvic and Rectal	10	19		23	2	4	4	10	27	6	42	12	2	5	63	23	252
Pelvic and Blood Pressure				1	1			1									3
Rectal and Blood Pressure	4	2			1	2	1									1	11
Pelvic, Rectal and Blood Pressure	2	1	15	5	1		2	6	2		1	1			1	2	39
Total Incomplete Charts	30	33	15	48	10	11	17	23	40	11	49	18	10	9	75	39	438

Table 5—Investigations of Patients, Gall Bladder Audit

Investigation	Excessive		Insufficient		Inappropriate		Total
	Medical Patients	Surgical Patients	Medical Patients	Surgical Patients	Medical Patients	Surgical Patients	
Laboratory	1	1	47	27			76
X-ray	1		47	24	1	1	74
Special Studies			31	18	3	3	55
Total	2	1	125	69	4	4	205

Table 6—Evaluation of 341 Operations, Gall Bladder Audit

Evaluation	Operations
Pre-op. and Tissue Diagnoses did not agree	2
Final and Tissue Diagnoses did not agree	1
Surgery not justified	3

Table 4 presents data about the absence of recorded blood pressure readings and pelvic and rectal examinations in the medical records. It is not known why 13 patients did not have a blood pressure reading recorded, and there would seem to be no adequate explanation for this deficiency. It is possible that most of the patients without recorded pelvic and rectal examinations were private patients who had had these examinations done by their doctors previous to hospital admission. It is equally possible that pelvic and rectal examinations were just not done either before or during hospital admission. Blood pressure readings should be a constant recorded finding in every adult physical examination; pelvic and rectal examinations are an integral part of the examination of every adult, and one would not expect to find such a high proportion of patients for whom these examinations were not recorded.

Table 5 presents data about the adequacy of laboratory and x-ray examinations and special diagnostic studies. Of the total of 643 patients, 205 (32 per cent) were criticized for deficiencies of the use of these diagnostic facilities. Of these 205 deficiencies, 194 (94 per cent) were judged to be for "insufficient studies." This finding of insufficient use of the laboratory and x-ray diagnostic facilities is not unique in our experience with the medical audit. This same criticism has been made by the medical staffs of the participating hospitals in each of the audit studies conducted so far. This, of course, should be of particular interest to Blue Cross plans and other third-party payment organizations which have claimed frequently that too many laboratory and x-ray examinations are made on hospital patients.

Table 6 shows the results of evaluation of one form of treatment of hospital patients, that of surgery performed on 341 patients. Two facts are

of interest: (1) the high rate of accuracy of preoperative diagnoses (99.4 per cent), and (2) the high rate of justified surgery (99.1 per cent). This excellent rate of justification for surgery is due largely to the efficiency of modern diagnostic aids, and particularly the x-ray, in making an accurate preoperative diagnosis of disease of the gall bladder. This is in marked contrast to the accuracy of preoperative diagnosis in the case of the appendix, where diagnostic laboratory and x-ray examinations are frequently unrevealing, and it is not possible always to make an accurate preoperative diagnosis (Table 7).

Table 8 shows the results of evaluation of one form of treatment which is common to all patients, medical as well as surgical—treatment with drugs. Only four categories, out of a total of 13 evaluated, are presented in this table. Three of these, chemotherapy and antibiotics, narcotics and sedatives, were the most frequently given medications; and the first two categories were the most frequently criticized. Mention should be made here that chemotherapy and the antibiotics have been the most frequently criticized drugs in our experience with the audit of other disease conditions and almost always because of excessive use.

The evaluation of the use of blood, plasma and blood volume expanders was included in Table 8 for two reasons: (1) These agents are among the most frequent therapy given in this series, and (2) the use of whole blood varies markedly among the various hospitals (Table 9). This table shows the transfusion rate to vary from 0 to 75 per cent; in only four instances was the use of blood criticized and three of these were for not giving blood.

Table 10 shows the opinions of the evaluating physicians concerning the general management of these patients. Seventy-six (12 per cent) were thought to have received "superior" care, a category specified to be for exceptional management; 507 (79 per cent) received "good," the expected care; 43 (7 per cent) were judged to have received "fair" treatment, and 9 (1 per cent) were thought to have been "poorly" managed. It is possible that the differences between hospitals as to the proportions rated "superior," "good," "fair" and "poor" represent differences in the standards applied by the medical audit committees of these various hospitals. Actually, this particular type of evaluation, which attempts to give a "batting average" for all aspects of the care of a patient

Table 7—Surgical Performance Statistics

Surgical Performance Statistics								
				Appendectomy				
Hospital No.	No. of Beds	Location	Interns, Residents	Total Operations	Justified, %	Not Justified, %	Accuracy of Diag. nosis, %	Normal Tissue Removal, %
1	250+	Urban	Yes	49	86	14	70	27
2	500+	Urban	Yes	31	77	23	77	0
3	300+	Rural	Yes	49	94	6	86	4
4	50+	Rural	No	198	76	24	63	0
5	50+	Rural	No	37	59	41	56	38
6	250+	Urban	Yes	100	97	3	84	9
7	125+	Urban	Yes	91	97	3	88	12
8	200+	Urban	Yes	77	97	3	83	14

Table 8—Treatment or Drug Evaluation, Gall Bladder Audit

Treatment or Drug	Not Given or not Evaluated		Given, Properly		Should have been Given		Therapy Given: Too Much		Therapy Given: Too Little		Not Appropriate		Contraindicated		Total Criticisms
	M	S	M	S	M	S	M	S	M	S	M	S	M	S	
Chemotherapeutics and Antibiotics	190	103	105	233	1	2	1		1		4	3			12
Narcotics	142	40	155	301	1		3						1		5
Sedatives	115	49	186	292			1								1
Blood, Plasma, Blood Vol. Expanders	282	228	19	109		3	1	1							5
Total	729	420	465	935	2	5	6	1	1		4	3	1		23

and of groups of patients, is of less significance than the evaluation of individual phases of such care. The reason for this is that the total care of a patient is rarely all good or all bad, and it is usually extremely difficult for the evaluating physician to balance credits and deficiencies and arrive at a valid rating for the entire care of the patient. However, this table does illustrate the willingness of these audit committees to record their criticisms of the professional work of their colleagues and indicates the willingness of a representative segment of the medical profession to discipline itself.

I have presented a brief review of the use of the medical audit as developed by the American College of Surgeons and the Commission on Professional and Hospital Activities. This new method not only has established criteria which are valid and inclusive of the significant aspects of patient care but it also provides a means of tabulating and correlating data which could not be realized without the use of modern business machines.

One thing is certain: Some form of medical audit similar to the one presented here will be used routinely in the future. The intelligent and effective care of patients will require it.

Table 9—Use and Criticism of Blood, Surgical Patients, Gall Bladder Audit

Hospital	Surgical Patients	Transfusion Rates	Criticism of Blood Use	
			Improperly Withheld	Too Much Given
1	23	26%		
2	19	16		
4	9	0		
5	33	15		
6	20	68		1
7	7	28		
8	13	75		
9	16	36		
10	31	28		
12	21	35		
14	32	47		
16	9	0	2	
17	1	*		
18	18	*		
19	54	*	1	
20	35	*		
Total	341		3	1

*Data not available at time of preparation of table.

Table 10—General Management of Case, Gall Bladder Audit

Hospital	Total Patients	General Management				
		Superior 1	Good 2, 3	Fair 4, 5, 6	Poor 7, 8, 9	Not Stated
1	36	6	23	7		
2	42	1	39			2
4	19		19			
5	61	24	35	2		
6	28	4	24			
7	17		16	1		
8	34	1	32	1		
9	42	9	23	2	4	4
10	43	1	40	1	1	
12	33	1	32			
14	62		58	4		
16	19		17			2
17	30		30			
18	36	21	13	2		
19	79	8	52	15	4	
20	62		54	8		
Total	643	76	507	43	9	8

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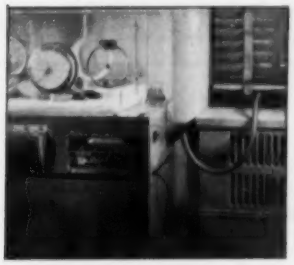

1. True Isolation: Only the ISOLETTE® continuously draws in fresh, pathogen-free air from outside the nursery, forces out used air, protects the infant from air-borne or droplet infection. The ISOLETTE completely replaces incubator air every 15 minutes, approximately.

2. Constant Circulation of Fresh, Warm Air: The ISOLETTE alone provides a continuous supply of clean, fresh air, with precise control of warmth, humidity, and extra oxygen (when needed)—features impossible to achieve without controlled, mechanical air circulation.

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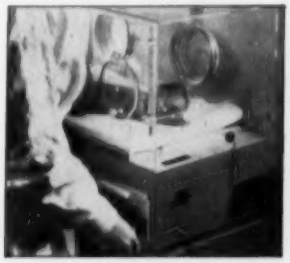
In incubator care of **the small premature infant . . .**

. . . the ill premature infant . . . the infant requiring isolation



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*Dunham, E.C.: *Premature Infants*, 2nd Ed., Hoeber-Harper, New York, 1955

Treatment of Syphilis

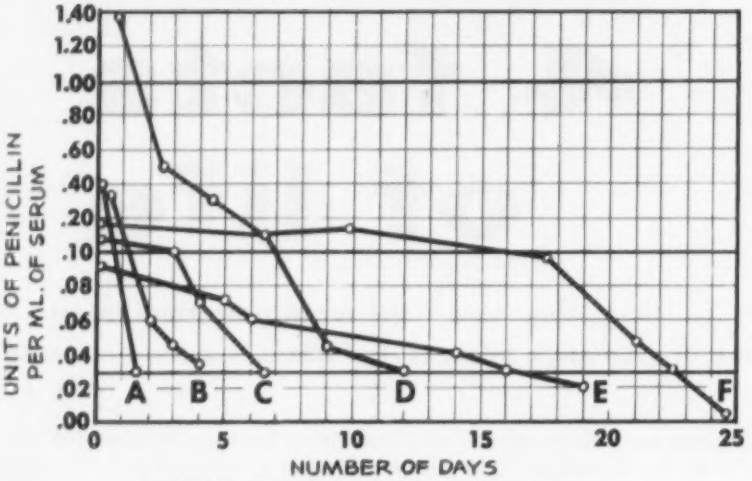
IN JUNE 1943 Mahoney, Arnold and Harris[1] demonstrated that penicillin was effective in the treatment of early syphilis in the rabbit and in man. Through an intensive study by a combined armed forces and civilian investigation group under the direction of the National Research Council, it was soon shown that penicillin was effective in the treatment of both early and late syphilis as well as in the prevention of prenatal syphilis.

A stern campaign has been waged against syphilis, and the success of this country's health agencies and the medical profession in the control of the disease is one of the great achievements of public health history. The success of the syphilis control program is evidenced in the accompanying data from the U.S. Public Health Service reports:[2]

Effect of penicillin and the time factor. Penicillin has a direct bactericidal effect on many micro-organisms *in vitro*. The mode of action *in vivo* is not fully known, but it is probable that the antibiotic is absorbed or adsorbed by the micro-organisms, so that cellular respiration is inhibited and the assimilation of glutamine and lysine and the breakdown of nucleins are blocked.[3,4] The mechanism does not seem to be affected directly by the immunobiological defense processes of the host.

Treponema pallidum is one of the most penicillin-sensitive micro-organisms known. As little as 0.0025 unit per ml. will immobilize 50 per cent of the treponemes within 16 hours.[5] However, to kill Treponema pallida requires exposure to penicillin over a longer period of time than is the case with other micro-organisms. To achieve the most effective results it is therefore essential to consider the duration of treatment as well as the total dosage to be employed. The multiplication time of Treponema pallida *in vivo* is approximately 30 hours.[6] The penicillin concentration in the blood during any regimen for treating syphilis should not fall under the treponemacidal level to avoid the opportunity for spirochetes to recuperate and multiply. A continuous penicillin blood level of 0.03 units per ml. of serum or higher, maintained over a sufficiently long period of time, has proved therapeutically effective. Although Treponema pallida have developed resistance to the arsenical drugs occasionally, no penicillin-resistant treponeme strain has yet been reported.[7]

Comparison of Duration of Therapeutic Penicillin Blood Levels Between Repository Preparations and Salts of Penicillin



A—300,000 units procaine penicillin in aqueous suspension.
B—300,000 units PAM.
C—300,000 units benzathine penicillin G.
D—2,400,000 units PAM.
E—1.5 million units benzathine penicillin G.
F—3.0 milliion units benzathine penicillin G.

Incidence of and Mortality Rates Resulting From Syphilis

	1939	1952
Mortality rate	11.1 per 100,000	3.7 per 100,000
Infant mortality	0.57 per 1000 live births	0.02 per 1000 live births
First admission to mental hospital	6.6 per 100,000	2.1 per 100,000
Reported syphilis (all stages)	367/100,000	100.8/100,000 (1953)
Reported primary and secondary syphilis	75.6/100,000 (1947)	6.27/100,000 (1953)
Reported congenital syphilis	17,600 (1941)	8,021 (1953)

Choice of penicillin preparation. Aqueous crystalline penicillin G injected several times daily during the treatment period gives high penicillin concentration of short duration in

Each SUR-BEX with C tablet contains:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	1 mg.
Vitamin B_{12} *(as cobalamin concentrate)*	2 mcg.
Calcium Pantothenate	10 mg.
Ascorbic Acid	150 mg.
Liver Fraction 2, N. F.	300 mg. (5 grs.)
Brewer's Yeast, Dried	150 mg. (2½ grs.)

As a dietary supplement: 1 or 2 tablets daily.

For stress, or postoperative convalescence: 2 or more tablets daily.

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TREATMENT SCHEDULES

Stage of Syphilis	*Dosage of Penicillin*
EARLY Primary Secondary	2,400,000 units PAM or benzathine penicillin G at first treatment (may be divided equally in both buttocks), followed by 6 injections at 4 day intervals of 600,000 units each. or 600,000 units procaine penicillin G in aqueous suspension daily i.m. for 20 consecutive days.
LATENT Early latent Late latent	600,000 units PAM or benzathine penicillin G twice weekly for 5 weeks. or 600,000 units procaine penicillin G in aqueous suspension daily i.m. for 15-20 consecutive days.
LATE Osseous Cutaneous Visceral Mucous membranous Cardiovascular Neurosyphilitic	600,000 units PAM or benzathine penicillin G on alternate days until a total of 9,000,000 to 12,000,000 units has been administered. (In cardiovascular and neurosyphilis this course may be repeated after 3-4 months if believed indicated.)
PREGNANCY	600,000 units PAM or Benzathine penicillin G twice weekly for 4 weeks. or 600,000 units procaine penicillin G in aqueous suspension i.m. daily for 10-15 consecutive days. If labor is imminent: 2,400,000 units PAM immediately. Repeat in 1 week if infant has not been delivered.
CONGENITAL Early (patient less than 2 years of age)	20,000 units PAM per pound of body weight twice weekly for 4 weeks. or 20,000 units procaine penicillin G in aqueous suspension per pound of body weight given daily for 10 consecutive days.
Late (patient 2 years of age or over)	600,000 units PAM or benzathine penicillin G twice weekly for 5 weeks.
PROPHYLAXIS If definite exposure to early syphilis is known	2,400,000 units PAM in one treatment (divided equally in both buttocks).

According to the 1954 survey by the World Health Organization, penicillin produces side reactions in approximately 3 per cent of patients, the reactions rarely being severe enough to require discontinuation of treatment. The use of Penicillin V in syphilis is still under evaluation.

serum and tissues, and its use usually involves the hospitalization of the patient. Procaine penicillin G in aqueous suspension permits ambulatory treatment with the use of a single daily injection over a designated number of days or weeks. The long duration of therapeutic penicillin blood levels after use of repository penicillin preparations, such as procaine penicillin G in oil with 2 per cent aluminum monostearate, or benzathine penicillin G in aqueous suspension, as compared to the more rapidly absorbed salts of the antibiotic, is demonstrated in the graph[8] on page 110.

General therapeutic principles. The stage of the disease, general health of the patient, his age, other coexistent diseases, individual tolerance to the antibiotic, as well as many other factors, must be considered in selecting a treatment regime. A prolonged follow-up over a period of years is essential and should include regular physical and serologic examination.

Antibiotics other than penicillin. Although clinical and experimental evidence shows that penicillin is the most effective and dependable antibiotic available in the treatment of syphilis, in the presence of definite patient intolerance to penicillin one of the other antibiotics may be substituted.

Aureomycin may be given orally, employing a dosage of 2 grams daily until a total of 40 grams of the antibiotic has been given. Since individual doses exceeding 250 mg. are not completely absorbed, this dose is usually given at three-hour intervals

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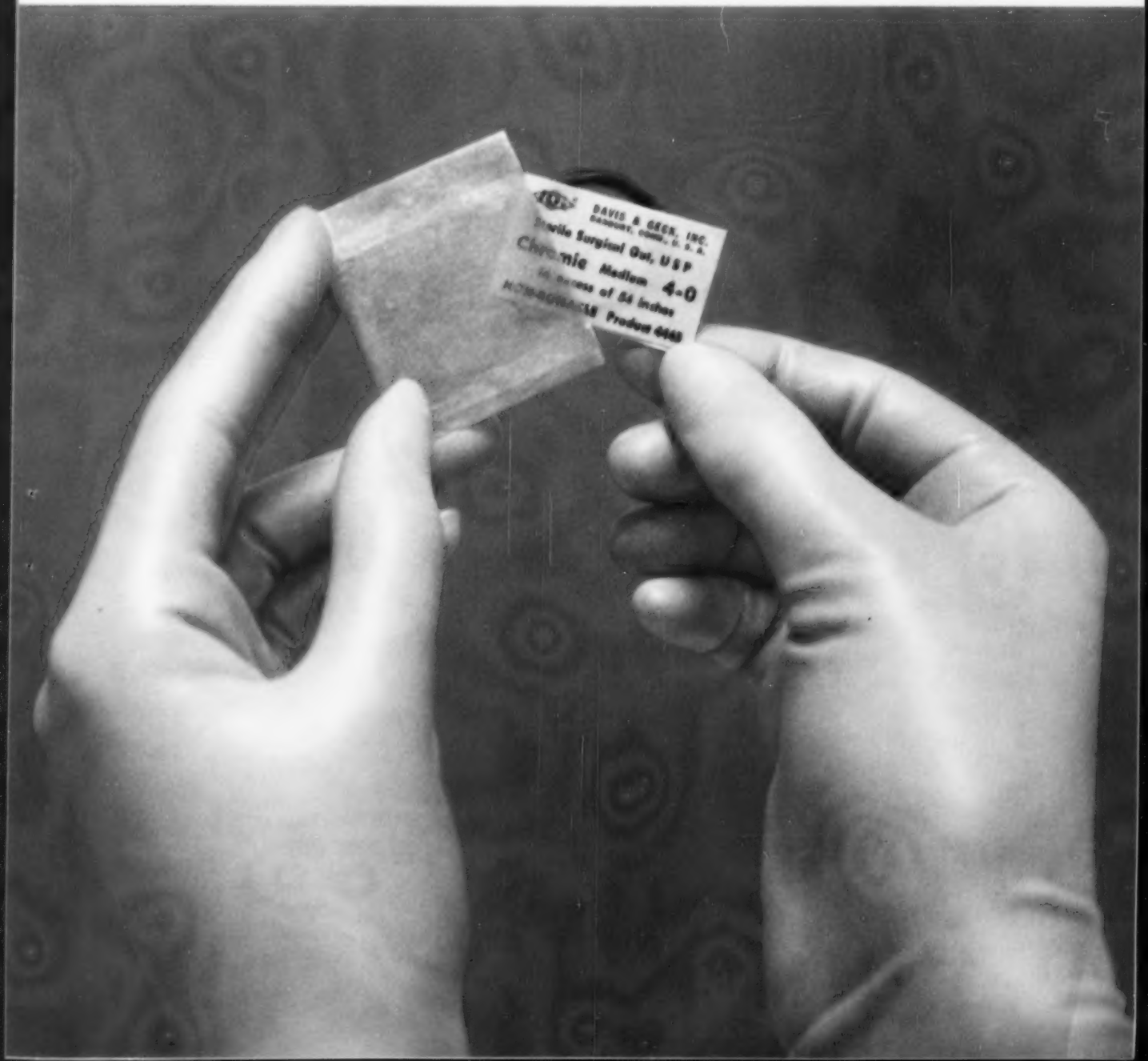

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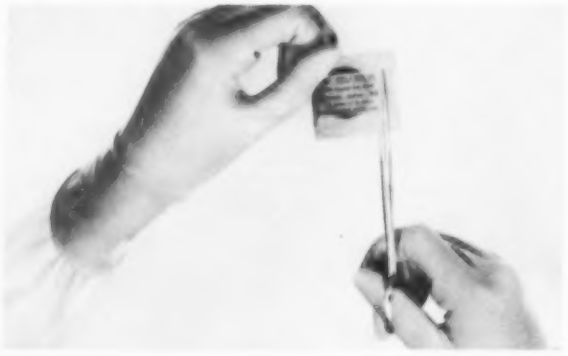

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3 *No more shattered tubes!* Suture nurse quickly removes ready-to-use sterile suture, individually wrapped in easy-to-read label. Nurses report they no longer worry about cut gloves, damaged linens and accidental tube breakage.

4 *SURGILAR delivers more flexible gut!* Suture nurse quickly straightens loose coil of doubled 54" strand. Surgeons report D & G SURGILAR delivers a stronger, more flexible strand of gut. Eliminates reel-wound gut that is weakened by sharp bends and is difficult to straighten. Costs no more than tubes.

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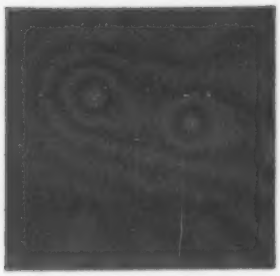
with milk, along with daily administration of multivitamin therapy. Terramycin, chloramphenicol, erythromycin orally, and parenteral aureomycin, terramycin and chloramphenicol show definite antisyphilitic activity but are apparently inferior in their total effect as compared with the results obtained with adequate use of penicillin.

Treatment agents other than antibiotics. A questionnaire was circulated by the World Health Organization in 1953 to leading syphilologists and clinics in the world. There were 277 replies from 55 countries revealing that in 65 per cent of the treatment schedules for early syphilis submitted penicillin only was used. In North America all clinics relied solely on penicillin for treatment of early syphilis (in the absence of intolerance to it). However, in selected instances in late syphilis, such as aneurysm, evidence of coronary artery involvement, marked late hepatic syphilis and the like, it is often justifiable to institute therapy with six or eight injections of bismuth subsalicylate given i.m. at one-week intervals, the purpose of this "preparation" course being to forestall a disastrous Herxheimer reaction when penicillin therapy is instituted in that case. Its treponemicidal effect is believed produced by its affinity for the sulfhydryl group in the spirochete. The usual adult dose is 1.5 cc. of 10 per cent bismuth subsalicylate in oil suspension.

Iodides have no antispirochetal effect but have long been observed to have a healing effect on the lesions of late syphilis. As in other chronic granulomatous conditions, its effect may be due to its neutralization of the antitryptic substance in the blood, thus promoting absorption and healing of gummatous tissue. In the absence of coexisting tuberculosis or thyroid disease, iodides are of value in the relief of pain in osseous and cardiovascular syphilis and for promoting the healing of gummas. Usually from 10 to 20 drops of saturated solution of potassium iodide are given orally in water three times daily for two or three months in selected cases.—LOUISE E. TAVS, M.D.

1. Ven. Dis. Inf. **24**:355, 1943.
2. Am. J. Syph., WHO report, Vol. 37, 1953.
3. J. Gen. Microbiol. **1**:314, 1947.
4. Arch. Biochem. **12**:57, 1947.
5. Ann. New York Acad. Sci. **55**:1161, 1952.
6. Am. J. Syph. **32**:1, 1948.
7. Am. J. Syph. **37**:369, 1953.
8. Adapted from Bull. WHO, **10**:515, 516 (figs. 2, 3), 1954.



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Centralize Food Control for Efficiency

St. Luke's centralized system of food purchasing and control reduces waste and cost of food and labor

HELEN E. CASSIDY

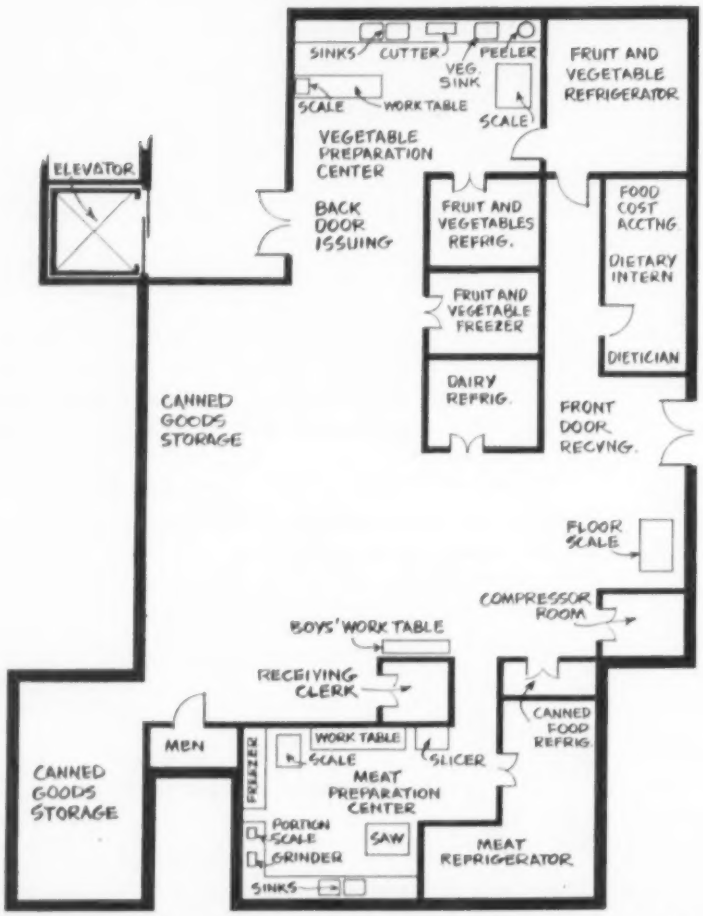
EFFICIENT food cost control can be achieved only when the method of control checks every operation with an accuracy and thoroughness that eliminate any loophole or possible error. Setting up such a system requires careful planning and organization, prefaced by a careful survey of existing conditions. When such a system has been set up and put into operation only the first hurdle has been taken. The staff must check constantly for 100 per cent execution and follow-through. The success of a food purchase and control system will depend upon this.

The staff of St. Luke's Hospital, New York City, began a survey of kitchens, kitchen practices and food cost control in 1948. The following objectives were listed for specific consideration and investigation: (1) to save labor; (2) to check for and eliminate any repetitious operation (for example, two bakeshops were consolidated); (3) to check menu construction; (4) to standardize recipes; (5) to standardize and price portions; (6) to set up efficient purchasing practices; (7) to install a continuing perpetual inventory; (8) to set up an efficient system of keeping records and accounts, and (9) to devise a simple, workable check system for all operations. The results of the survey pinpointed centralization as the starting point.

St. Luke's Hospital remodeled its

Miss Cassidy is purchasing dietitian of St. Luke's Hospital, New York City.

LAYOUT OF REMODELED STOREROOM, ST. LUKE'S HOSPITAL, NEW YORK CITY



The storeroom was constructed around an existing bank of refrigerators.

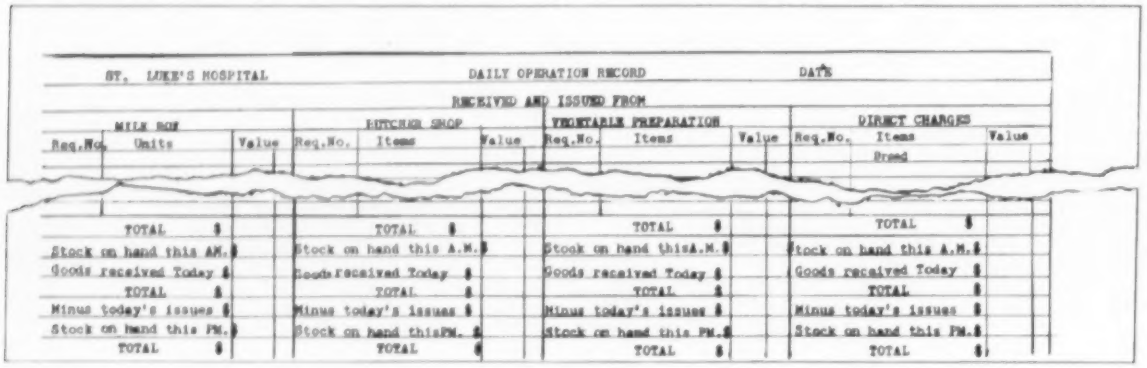
storeroom in 1952 to centralize buying, storing, testing, requisitioning and issuing of food. Through centralization, waste and cost of food and labor were materially reduced. It was also possible to change the system of record keeping, to account daily for the money spent, and to keep track of the daily and cumulative meal cost.

The diagram on page 116 shows how the new layout for the storeroom was constructed around the existing central bank of refrigerators, as these had already been built at considerable expense. The dietitian's office is just inside the delivery entrance, making it easy and convenient to check deliveries with the receiving clerk. The receiving clerk's office is so situated that he receives and supervises the storing of food supplies. He also issues all food. The storeroom has two doors, one for receiving and one for issuing food supplies. The doors are kept locked and only storeroom personnel is permitted to enter.

A master menu is made by the dietitian in charge and sent for approval to the director of dietetics, the therapeutic dietitian, and dietitians of the main kitchen, the private kitchen and the two pay cafeterias. A selective menu is used throughout the house. A basic menu is made out for the wards and semiprivate patients; this with additions and changes takes care of the special requests of the private patients. After the menu has been approved and returned to the main dietary office it is typed and duplicated for distribution. Tuesday of each week the dietitians check (for the following week) a copy of the menu with the number of servings requested of meat, fresh fruit, other fruit, and vegetables. These are submitted to the purchasing dietitian. She compiles the items, checks storeroom inventories, takes bids, and then places the orders. Records are kept on each group.

INVENTORY ITEMS

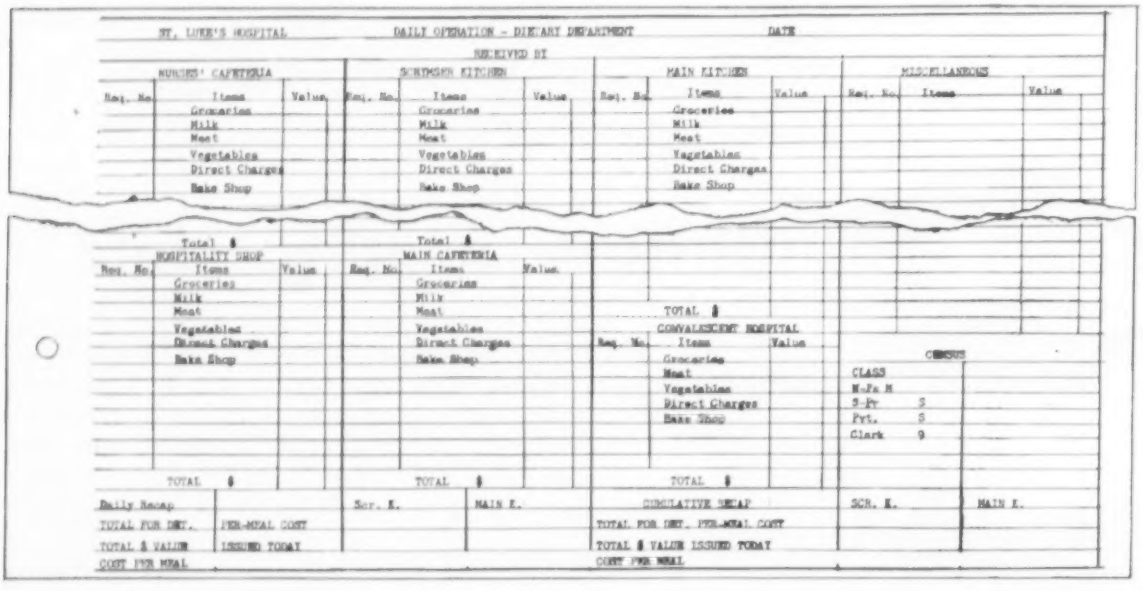
All inventory items are ordered out of stock on white requisition forms. Orders must be placed with the purchasing dietitian in the storeroom by 7 o'clock each morning to be checked for stock numbers and quantities to be ordered. Each requisition receives a number; this is checked off as the requisition is checked out, and again when it is returned to the storeroom after delivery. When the cycle is completed from the kitchen to the storeroom and then from the storeroom to the kitchen and back to the storeroom again, the


ST. LUKE'S HOSPITAL — DAILY OPERATION RECORD — DATE

RECEIVED AND ISSUED FROM

MILK BOX			BUTCHER SHOP			VEGETABLE PREPARATION			DIRECT CHARGES		
Req.No.	Units	Value	Req.No.	Items	Value	Req.No.	Items	Value	Req.No.	Items	Value
										Bread	
TOTAL $			TOTAL $			TOTAL $			TOTAL $		
Stock on hand this AM. $			Stock on hand this A.M. $			Stock on hand this A.M. $			Stock on hand this A.M. $		
Goods received Today $			Goods received Today $			Goods received Today $			Goods received Today $		
TOTAL $			TOTAL $			TOTAL $			TOTAL $		
Minus today's issues $			Minus today's issues $			Minus today's issues $			Minus today's issues $		
Stock on hand this PM. $			Stock on hand this PM. $			Stock on hand this PM. $			Stock on hand this PM. $		
TOTAL $			TOTAL $			TOTAL $			TOTAL $		

Above: The daily operation record lists the "milk box," butcher shop, vegetable room, bakeshop, and direct charges. Below: The various units of the hospital and items received by each are entered on the reverse side of record.


ST. LUKE'S HOSPITAL — DAILY OPERATION - DIETARY DEPARTMENT — DATE

RECEIVED BY

NURSES' CAFETERIA			SCHWESTERN KITCHEN			MAIN KITCHEN			MISCELLANEOUS		
Req. No.	Items	Value	Req. No.	Items	Value	Req. No.	Items	Value	Req. No.	Items	Value
	Groceries			Groceries			Groceries				
	Milk			Milk			Milk				
	Meat			Meat			Meat				
	Vegetables			Vegetables			Vegetables				
	Direct Charges			Direct Charges			Direct Charges				
	Bake Shop			Bake Shop			Bake Shop				
Total $			Total $								

HOSPITALITY SHOP			MAIN CAFETERIA			CONVALESCENT HOSPITAL		
Req. No.	Items	Value	Req. No.	Items	Value	Req. No.	Items	Value
	Groceries			Groceries			Groceries	
	Milk			Milk			Meat	
	Meat			Meat			Vegetables	
	Vegetables			Vegetables			Direct Charges	
	Direct Charges			Direct Charges			Bake Shop	
	Bake Shop			Bake Shop				
TOTAL $			TOTAL $			TOTAL $		

CENSUS

CLASS	
M.&S.M.	
S-Pt.	5
Pvt.	5
Clerk	9

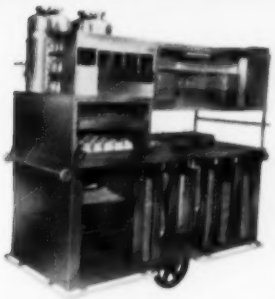
Daily Recap		Scr. K.	MAIN K.
TOTAL FOR DEP'T.	PER-MEAL COST		
TOTAL $ VALUE	ISSUED TODAY		
COST PER MEAL			

CUMULATIVE RECAP		SCR. K.	MAIN K.
TOTAL FOR DEP'T. PER-MEAL COST			
TOTAL $ VALUE ISSUED TODAY			
COST PER MEAL			

new *Mobilteria** system

TRADE MARK REG. U.S. PAT. OFF.

maximum efficiency at minimum cost!



The Mobilteria is the only self-contained unit serving 100 meals! Built of stainless steel . . . easily cleaned! Designed to meet rigid national, regional and local health department requirements. Approved by the National Sanitation Foundation.

See the Mobilteria on display in Booth 567 at The American Hospital Association Convention September 17-20 in Chicago, Ill.

Introduction of the New Mobilteria System to modern hospital meal service has met with immediate national recognition! Progressive institutions are enthusiastic in having this new system that gives all of the advantages of centralized and decentralized dietary services without the extra costs and headaches!

There's No End To The Savings With Mobilteria!

save... **revenue producing space!** The Mobilteria operates in the halls near the bedside. It serves fresh, hot and cold foods . . . complete meals plus beverages . . . on the spot!

save... **on the serving personnel!** Three people efficiently serve one hundred patients in one hour. The Mobilteria system allots full responsibility to the dietary department and relieves all but one skilled nurse from the duties of supervising trays, and special diets.

save... **time!** Patient serving time reduced by 50%. Paper work is cut to a minimum by eliminating menu orders. The communication system is also relieved.

save... **money!** There's no waste in food returns! A report from one hospital reveals that the Mobilteria is saving them $9,464.00 per year! This means that the low unit cost of the Mobilteria is more than paid for through savings, in the first six months of operation.

*U. S. PAT. #175888
(other patents pending)

Free Brochure sent to you immediately! Contact HOOD-Gardner for information of the installation nearest to you.

HOOD-Gardner

HOTEL SUPPLY CORP., CHARLOTTE, N.C.

requisitions are turned over to the food cost accountant who takes the items off the perpetual inventory, prices them, and lists prices on the requisition.

Canned inventory items are ordered in by the purchasing dietitian every four to six weeks. A bid sheet is then compiled, consisting of items, specifications and quantities to be ordered. Prices and comments are filled in by the companies and returned on a set date. This is done by mail. Testing on canned items is done in the storeroom. Perishable inventory items are ordered every few days by phone. A close check is kept to see that all items are moving. Any items that are seldom used are discontinued from the lists. A periodic check is made and seldom used items are deleted from the perpetual inventory.

FROZEN FOOD

Frozen food is an inventory item. Contracts, let for a year, are made only after rigid testing by several of the staff. The testing takes place early in the fall when quality is not likely to vary. Orders can then be placed by telephone once a week, based on compilations of orders from the several kitchens. Handling the ordering this way eliminates guesswork and keeps the inventory down. Frozen items are requisitioned daily on a white requisition form, by number of units and the stock number.

DAIRY PRODUCTS

All milk products have a stock number, but are a direct charge. The milk is requisitioned on a blue form that is sent to the storeroom a day early. Here the orders from all kitchens are compiled and then placed. The amount ordered is the exact total required by the kitchens.

FRESH FRUITS AND VEGETABLES

These are ordered in daily (a day in advance), Monday through Friday. The purchasing dietitian compiles the number of servings listed by each unit and converts it into amount to be purchased. All fruits and vegetables are bought by the pound and charged to the vegetable room. The vegetable room in turn sells to the kitchens. In ordering vegetables, the kitchens send down work sheets with specific instructions as to how the vegetables are to be prepared. These instructions are carried out by the vegetable men; weights are then summarized on green requisition forms, priced by the receiving clerk, and checked by the food cost accountant.

MEAT

Meat is charged directly to each kitchen as it is delivered. Preparation is done in the butcher shop and portion scales are used as controls. Part of the meat purchased is already prefabricated, and in any case all of it is completely trimmed. The kitchens order the number of servings needed on the menu and requisition it out on a pink requisition form. The butcher receives a copy of the amount of meat ordered to cover the amounts needed. He reports any difference in yield, whereupon a check is made.

Fish is ordered once a week and oftener if necessary. It is ordered and charged the same way as meat. The butcher has a portion scale at his elbow at all times and uses it constantly. Each kitchen is also equipped with a portion scale. By this method the meat and fish check operates accurately.

BAKED PRODUCTS

The bakeshop, located in the main kitchen, does the baking for the entire

back-to-back counters save equipment and labor

AT ST. VINCENT'S HOSPITAL, WORCESTER, MASS.

ideas from Blickman-Built food service installations

SAVINGS IN EQUIPMENT AND LABOR result from the back-to-back arrangement of cafeteria counters. Both are served by a common back-bar and food storage facilities. One cashier handles both lines. Personnel can be reduced during "slack" periods, since one attendant can operate similar stations at both counters. Stainless steel construction aids sanitation.

• This installation at St. Vincent's Hospital shows how to plan for economy without sacrificing efficiency. In the cafeteria, two stainless steel counters are arranged back-to-back so that each shares the same back-bar and food storage facilities. Equipment costs are kept to a minimum . . . service fully meets the needs of the institution. In the main kitchen, economies are also obtained through use of Blickman-Built equipment which permits orderly, convenient food preparation and low-cost sanitary maintenance. Let us show you how "Blickman-Built" can mean virtual built-in efficiency and economy for your food service installation.

BUILT-IN EFFICIENCY is reflected in the equipment for the cooking section. The stainless steel cook's table, close to ranges and ovens, has built-in warmers, built-in bain marie and pot rack. Crevice-free work surfaces simplify cleaning. Raised tile bases also aid sanitation by eliminating hard-to-clean inaccessible areas.

This illustrated folder gives more information about Blickman-Built food service installations. Send for your free copy today.

Blickman-Built
MASS FEEDING EQUIPMENT

For Service Life Measured In Decades

S. BLICKMAN, INC., 1507 GREGORY AVENUE, WEEHAWKEN, N. J.

hospital. All kitchens use a yellow requisition form to order from the bakeshop and are charged for purchases.

Requisitioning by the kitchens: The various colored requisition forms are used because each color designates particular foods, and makes it easier to do the calculation of the daily operation at the end of each day. The one side of the daily operation sheet lists the "milk box," butcher shop, vegetable room, bakeshop, and the direct charges. All bills are checked against the order for prices and specifications and the receiving ticket for the weight or amount received. The items are then entered on the sheet in the proper box and taken out by requisition. If there is a balance on hand it will show.

The other side of the daily operation record contains the headings "Nurses' Cafeteria," "Scrymser Kitchen," "Main Kitchen," "Hospitality Shop," "Main Cafeteria," "Convalescent Hospital," and "Miscellaneous." Having the purchasing dietitian on the scene saves time, transportation and explanations. This is imperative if the system is to work efficiently, and allows for intelligent changes in menus if required. Daily and cumulative meal cost is always available. Standardized recipes and uniform portion control, of course, must be carried on in all kitchens if the operation is to be completely effective.

Under each unit is listed: (1) groceries, (2) milk, (3) meat, (4) vegetables, (5) direct charges, and (6) bakeshop. This gives the total amount spent by each unit each day. The census is also listed on this side, and the cumulative and daily food cost of Scrymser and Main Kitchen.

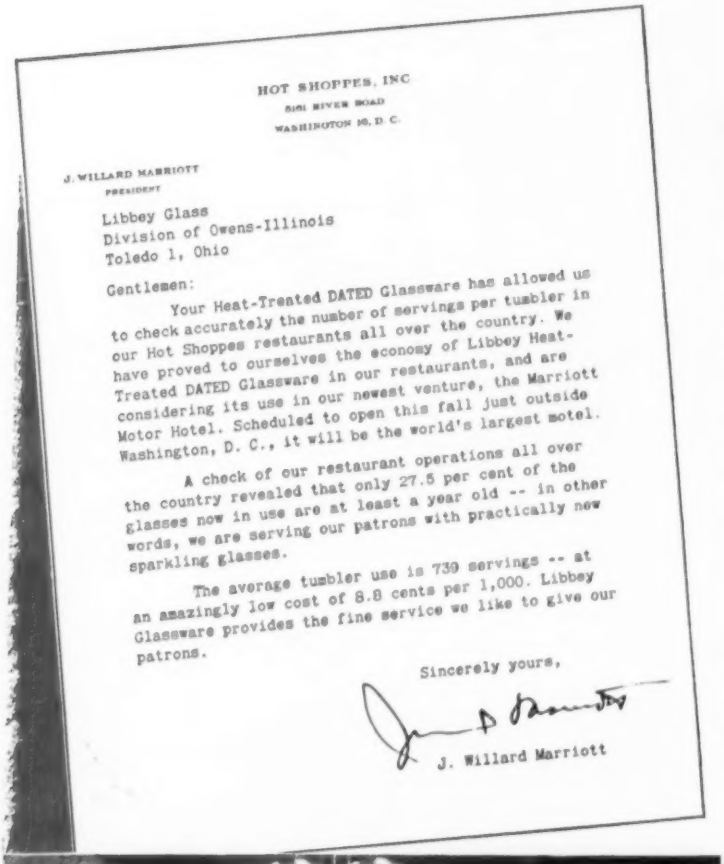
After completing the daily operating sheet, the food cost accountant* prepares a food summary sheet which is turned in to the accounting office at the end of the month. On the debit side appears: (1) Miscellaneous, (2) Nurses' Cafeteria, (3) Hospitality Shop, (4) Scrymser Kitchen, (5) Direct Charges, and (6) Bakeshop. On the credit side we have: (1) Stores Control, (2) Milk Box, (3) Butcher Shop, (4) Vegetables, (5) Direct Charges, and (6) Bakeshop. The debit and credit sides must balance, and when completed this proves the daily operation record.

Many times actual operation is lost in a maze of paper work; therefore all the forms and records used at St. Luke's are simple and comprehensive. Each contributes to the efficiency of the food control system.

Menu planning determines what the food will be; therefore the dietitian in the storeroom with the food cost control at her finger tips can plan accordingly. She may make changes if prices warrant it. Quality of food and selection for appeal to patients must never be lost sight of; price alone should not dictate purchases. Specifications and quality in relation to cost must be considered. Constant checking of deliveries, of new products or of old stand-bys, is essential to quality and cost control. Centralization reduces labor hours, eliminates waste, and saves time in actual preparation. Buying prefabricated and trimmed cuts of meat as needed yields uniform portions, permits exact food cost control, and also cuts down on shrinkage and inventory.

*The accountant, who is responsible to the controller of the hospital, prepares a food summary sheet which is turned in to the hospital accounting office at the end of the month. This satisfies the requirements in many institutions that the receiving clerk be in a department other than the dietary, presumably therefore acting as a control on employes of the dietary department.

"We can prove to ourselves the economy of Libbey Heat-Treated DATED Glassware"



HOT SHOPPES, INC
3101 RIVER ROAD
WASHINGTON 16, D. C.

J. WILLARD MARRIOTT
PRESIDENT

Libbey Glass
Division of Owens-Illinois
Toledo 1, Ohio

Gentlemen:

Your Heat-Treated DATED Glassware has allowed us to check accurately the number of servings per tumbler in our Hot Shoppes restaurants all over the country. We have proved to ourselves the economy of Libbey Heat-Treated DATED Glassware in our restaurants, and are considering its use in our newest venture, the Marriott Motor Hotel. Scheduled to open this fall just outside Washington, D. C., it will be the world's largest motel.

A check of our restaurant operations all over the country revealed that only 27.5 per cent of the glasses now in use are at least a year old -- in other words, we are serving our patrons with practically new sparkling glasses.

The average tumbler use is 739 servings -- at an amazingly low cost of 8.8 cents per 1,000. Libbey Glassware provides the fine service we like to give our patrons.

Sincerely yours,

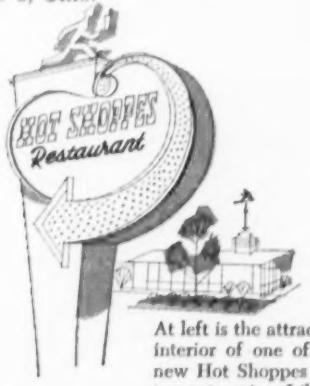
J. Willard Marriott

Mr. J. Willard Marriott
President of the
Hot Shoppes, Inc.

For seven years a code symbol on the bottom of every Libbey Heat-Treated glass has made it possible to trace this revolutionary ware in almost every type of use.

Mr. J. Willard Marriott, President of the Hot Shoppes, Inc., chain of Washington, D. C., and Past President of the National Restaurant Association, is convinced of the economy of Libbey Heat-Treated DATED Glassware . . . as are restaurant operators throughout the country. You can prove to *yourself* the economy of the world's first DATED Glassware . . . prove that Heat-Treating and the Libbey guarantee: "A new glass if the rim of a Libbey 'Safedge' ever chips" provide the finest glassware service at the lowest cost per serving.

Your Libbey Supply dealer has complete details. See him or write Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.



At left is the attractive interior of one of the new Hot Shoppes restaurants using Libbey Heat-Treated DATED Glassware. To check your own glasses just look at the Heat-Treated mark on the bottom of each tumbler. Numbers indicate date of manufacture—left shows year and right shows quarter. Add up the number of servings to see the amazing economy of Libbey Heat-Treated DATED glasses.

LIBBEY HEAT-TREATED GLASSWARE
AN (O) PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES • TOLEDO 1, OHIO

Menus for August 1956

1 Grapefruit Half Poached Egg, Toast • Roast Veal Oven-Browned Potato Spinach, Egg Slice Waldorf Salad Devil's Food Cake With Chocolate Frosting • Cream of Tomato Soup Broiled Ham Celery, Ripe Olives Hot Rolls, Jam	**2** Grape Juice Bacon, Muffins • Meat Loaf Parslied Potato Green Beans Beet, Onion Rings Cherry Cobbler • Cream of Pea Soup Stuffed Frankfurters Baked Potato Raw Vegetable Salad With French Dressing Fruit Gelatin With Whipped Cream	**3** Tomato Juice Hot Cakes, Sirup • Creole Shrimp on Rice Fresh Carrots Pineapple Salad Lemon Meringue Pie • Cream of Mushroom Soup Tuna Soufflé Green Peas Congealed Fruit Salad Frosted Cake	**4** Applesauce Soft Cooked Egg • Roast Lamb, Mint Jelly Creamed Potatoes Buttered Green Peas Pear, Cottage Cheese Salad Pumpkin Pie • Vegetable Soup Broiled Hamburgers French Fried Potatoes Lettuce, Tomato Salad With Mayonnaise Peach With Whipped Cream	**5** Orange Half French Toast, Honey • Smothered Chicken Natural Gravy Mashed Potatoes Green Beans Cranberry Salad Ice Cream • Tomato Soup Cold Cuts Potato Salad Pickles, Stuffed Olives Fruit Gelatin With Whipped Cream	**6** Stewed Prunes Bacon, Egg • Stew With Vegetables Escalloped Corn Coleslaw Apple Pie • Chicken Noodle Soup Escalloped Ham, Eggs Carrots, Peas Lettuce Wedge With 1000 Island Dressing Chocolate Pudding With Whipped Cream
7 Grapefruit Juice Soft Cooked Egg • Roast Beef, Gravy Steamed Rice Asparagus, Pimiento Celery, Carrot Sticks Upside Down Cake • Potato Chowder Creamed Beef in Toast Cups Candied Yams Pickled Beets Apricots, Cookies	**8** Stewed Fruit Bacon, Egg • Baked Ham Creamed Potatoes Green Beans Pickles, Ripe Olives Cherry Cobbler • Cream of Pea Soup Broiled Liver Baked Potato Tomato Wedge Icebox Pudding	**9** Pineapple Juice Hot Cakes, Sirup • Roast Pork Cinnamon Applesauce Yams Lettuce Wedge With French Dressing Fruit Gelatin With Whipped Cream • Chicken Rice Soup Lamb Chop, Mint Jelly Creamed Rice Carrots, Celery Peaches in Cream	**10** Grapefruit Half Scrambled Eggs, Bacon • Broiled Salmon With Tartare Sauce Macaroni, Cheese Sauce Fruit Salad Sherbet, Cookies • Vegetable Soup Creamed Eggs French Fried Potatoes Pear, Cottage Cheese Salad Fruit Gelatin With Whipped Cream	**11** Tomato Juice Poached Egg, Toast • Swiss Steak Mashed Potatoes Green Peas Carrot, Raisin Salad Gingerbread With Lemon Sauce • Spaghetti With Meat Sauce Mixed Vegetable Salad Hot Rolls, Jam Grapes	**12** Sliced Banana Soft Cooked Egg • Deviled Pork Chop Hot Applesauce Green Beans Coleslaw Apricot Cobbler • Cream of Mushroom Soup Broiled Ham Escalloped Potatoes Perfection Salad Cherry Pie
13 Pineapple Juice Sausage, Hot Cakes • Roast Turkey With Dressing, Giblet Gravy Yams, Marshmallow Cranberry Salad Mince Meat Pie • Creamed Turkey, Biscuit Pineapple, Cottage Cheese Salad Cranberry Sauce Orange Sherbet	**14** Stewed Prunes Bacon, Egg • Meat Loaf Creamed Potatoes Breaded Tomatoes Beet, Onion Rings Apricot Cobbler • Chicken Noodle Soup Broiled Hamburgers French Fried Potatoes Raw Vegetable Salad With French Dressing Fruit Gelatin With Whipped Cream	**15** Tomato Juice Poached Egg, Toast • Baked Ham Candied Yams Lima Beans Pickles, Ripe Olives Devil's Food Squares With Orange Frosting • Vegetable Soup Broiled Steak French Fried Potatoes Buttered Carrots Lettuce, Tomato Salad Spanish Pudding	**16** Sliced Orange Bacon, Muffins, Jam • Roast Beef, Gravy Mashed Potatoes Asparagus Complexion Salad Peach Pie • Corned Beef Hash Poached Egg Asparagus Salad Apple Float With Custard Sauce	**17** Grape Juice Soft Cooked Egg • French Fried Prawns With Tartare Sauce French Fried Potatoes Corn, Pimiento Lettuce Wedge With 1000 Island Dressing Peach With Whipped Cream • Clam Chowder Baked Macaroni, Cheese Vegetable Salad Lemon Meringue Pie	**18** Grapefruit Sections French Toast, Honey • Barbecued Spareribs Steamed Potato Harvard Beets Pickles, Ripe Olives Upside Down Cake • Tomato Soup Meat Loaf Creamed Potatoes Spinach, Egg Slice Carrot Sticks Orange Gelatin With Whipped Cream
19 Stewed Prunes Soft Cooked Egg • Braised Beef Shortribs Mashed Potatoes Baked Onions Asparagus Salad Coconut Custard • Vegetable Soup Broiled Hamburgers Pickles, Onion Slices Fruit Gelatin With Whipped Cream	**20** Sliced Banana French Toast, Honey • Fried Chicken Rice, Cream Gravy Carrots, Peas Cranberry Sauce Ice Cream • Cream of Mushroom Soup Chicken Salad Sliced Tomato Stuffed Olives Baked Apple, Cream	**21** Orange Juice Bacon, Egg • Roast Lamb, Mint Jelly Oven-Browned Potato Green Beans Carrot, Raisin Salad Upside Down Cake • Tomato Soup Baked Ham Yams Green Peas Crisp Relishes Apple Crisp	**22** Stewed Prunes Scrambled Eggs • Roast Pork, Applesauce Candied Yams Waldorf Salad Cake, Coconut Frosting • Cream of Asparagus Soup Swiss Steak Steamed Potato Spinach, Egg Slice Carrot Sticks Apricot Cobbler	**23** Grapefruit Juice Bacon, Muffins • Pot Roast Mashed Potatoes Breaded Tomatoes Pickled Beets Gelatin, Whipped Cream • Tomato Soup Spaghetti, Meat Sauce Chef's Salad Lemon Meringue Pie	**24** Grape Juice French Toast, Honey • Broiled Salmon, Lemon Creamed Potatoes Carrots, Peas Crisp Relishes Apricots, Cookies • Clam Chowder Macaroni, Cheese Sauce Buttered Green Beans Pear Salad Grapes
25 Sliced Orange Soft Cooked Egg • Deviled Pork Chop Lima Beans Buttered Carrots Cranberry Salad Baked Apple • Potato Chowder Broiled Ham Escalloped Corn Pineapple, Cottage Cheese Salad Peach With Whipped Cream	**26** Stewed Prunes Poached Egg, Toast • Smothered Chicken Natural Gravy Snowflake Potatoes Fresh Carrots Cranberry Salad Strawberry Sundae • Cream of Pea Soup Cold Cuts Potato Salad Pickles, Ripe Olives Fruit Gelatin With Whipped Cream	**27** Grapefruit Sections Soft Cooked Egg • Barbecued Spareribs Baked Yams Spinach, Egg Slice Waldorf Salad Apple Betty • Tomato Soup Broiled Liver, Bacon Escalloped Potatoes Green Peas Lettuce, Tomato Wedge Cake, Coconut Frosting	**28** Tomato Juice Bacon, Muffins, Jam • Stew With Vegetables Corn, Pimiento Lettuce Wedge With Russian Dressing Apple Pie • Consommé Broiled Lamb Chop With Mint Jelly Creamed Potatoes Buttered Carrots Ripe Olives Fruit Cup, Cookies	**29** Sliced Orange Poached Egg, Toast • Roast Pork With Cinnamon Applesauce Soufflé Sweet Potatoes Asparagus Salad Butterscotch Pudding With Whipped Cream • Corn Chowder Escalloped Ham, Eggs Buttered Carrots Mixed Vegetable Salad With French Dressing Devil's Food Cake	**30** Apricot Nectar Soft Cooked Egg • Roast Beef Parslied Potatoes Green Beans Complexion Salad Upside Down Cake • Vegetable Soup Giblets With Rice Green Peas Cranberry Salad Apricots, Cookies
31 Sliced Banana, French Toast, Honey • Salmon Loaf, Mash Potatoes, Green Peas, Coleslaw, Fruit Gelatin With Whipped Cream • Vegetable Soup, French Fried Shrimp with Tartare Sauce, Corn, Pimiento, Spinach, Egg Slice, Celery, Ripe Olives, Baked Custard					

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Any meal tastes better after Heinz Tomato Juice

No picking at food when you start the meal with a good cold glass of Heinz Tomato Juice. It spurs the appetite. People eat with real relish. It's the Heinz flavor that does it. The Heinz private strain of tomatoes produces a juice that's robust in flavor, sweet yet delicately tart, and uniform year after year. It's low in calorie content—21 calories per 100 grams of edible portion. In handy 5½ ounce "individuals," 46 ounce tins, or number 10 tins. Heinz Tomato Juice will not separate in the glass. Order on your Heinz man's next call.

CALIFORNIA PACK

HEINZ 57 TOMATO JUICE

YOU KNOW IT'S GOOD BECAUSE IT'S HEINZ

Scientific Approach Solves Laundry Problem

Better working methods developed from management studies have resulted in dollar savings and improved working conditions

KENNETH P. COHEN

SEVERAL months ago a new laundry was opened in an early phase of a building program at the Jewish Hospital of St. Louis. The obsolete machines were in most cases replaced with new semi-automatic and automatic laundry equipment. The area was more than doubled in floor space and laid out differently; thus working conditions were entirely changed from the old location.

Because of all these changes, it was decided to conduct a management engineering study in order to establish the most economical means of processing our linens under the changed conditions.

The major benefits which have resulted, or which will result after all changes mentioned in this report have been installed, are:

1. Weighing of sorted soiled linens eliminated.
2. Sorting operation simplified.
3. Much handling by flatwork feeders eliminated.
4. Much handling by tumbler operator eliminated.
5. Folding of uniforms eliminated by hanging them on rolling racks.
6. Approximately 50 per cent reduction in walking by linen room attendant.
7. Reduced handlings by flatwork folder and linen room attendant.
8. Total processing travel reduced approximately 44 per cent.
9. Change from the six-day week operation to the five-day week operation.
10. Reduction in personnel from 23 to 19, exclusive of the laundry manager. (At this writing we have 21 persons on the payroll, and attrition will reduce the complement to 19.)

(*Continued on Page* 128)

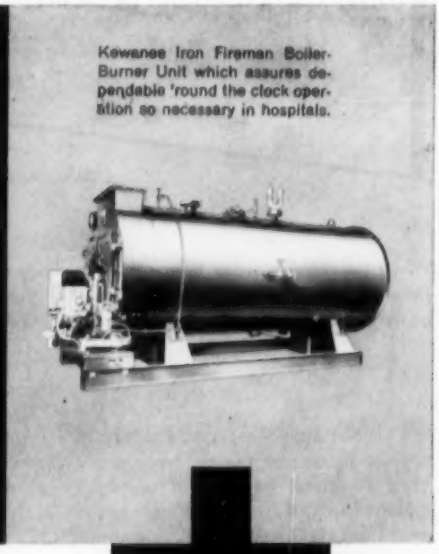
Mr. Cohen is administrative assistant at the Jewish Hospital, St. Louis.

A workman dumps an extractor load onto one of five portable tables designed to handle pieces of wet wash.

Uniforms are now hung on racks instead of being folded, thus eliminating travel to and from the old uniform room.

VITAL AS THE SURGEON'S TOOLS . . .
"CRUISING SPEED" BOILER OPERATION

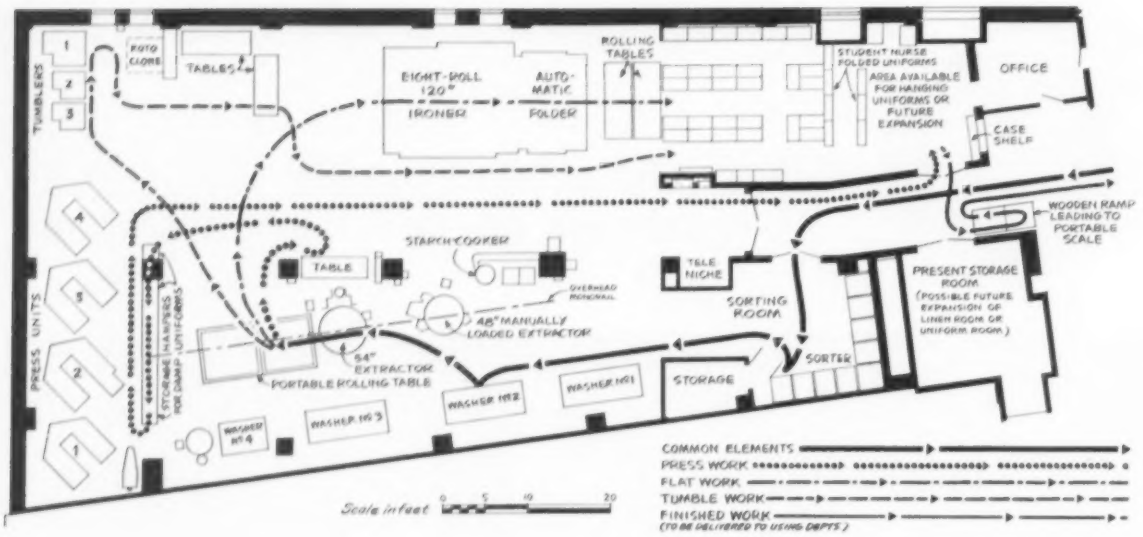
Hospital San Juan de Dios, Bogota, Colombia
Architect, Engineer & Contractor—Cuellar, Serrano & Gomez, Bogota, Colombia



■ A hospital never sleeps. 'Round the clock, day in, day out, it must be prepared to meet any emergency. And the "heart of a hospital"—the vital organ that supplies power for all steam equipment—is the boiler unit. With human life constantly at stake, the boiler must be infallible. That's why the administrators of Hospital San Juan de Dios, in Bogota, Colombia, chose Kewanee Reserve Plus Rated Boilers with 50% extra built-in power. They demanded dependable boiler operation with minimum maintenance and lower operating cost—higher efficiency. Operating at "cruising speed," Kewanee Boilers, rated on nominal capacity, offer that measure of protection always "on call" no matter what the need. And because of "cruising speed" operation, there is no prolonged strain with attendant chance of breakdown. Result: higher efficiency at lower cost with longer boiler life. Boilers rated on maximum capacity, operating wide open all the time, cost more to operate and maintain, are less dependable and are subject to breakdown. That's why hospitals all over the world prefer Kewanee Boilers. You will, too, if you investigate the Kewanee Boiler "cruising speed" story. Write now for facts. KEWANEE BOILER DIVISION OF AMERICAN-STANDARD, 101 Franklin Street, Kewanee, Illinois.

KEWANEE BOILERS

DIVISION OF AMERICAN-Standard



When the studies were begun a flow diagram was made showing conditions that existed in the laundry. On the basis of the management engineering studies, the layout and flow of work were changed as shown in the revised flow diagram above. These changes eliminated much duplication of work, crossing of traffic, and travel time.

11. Net annual estimated saving of approximately $4300 in labor costs. (Gross annual savings of approximately $4850 were reduced to the net figure because the laundry personnel now works six overtime days to compensate for six holidays during the year.)

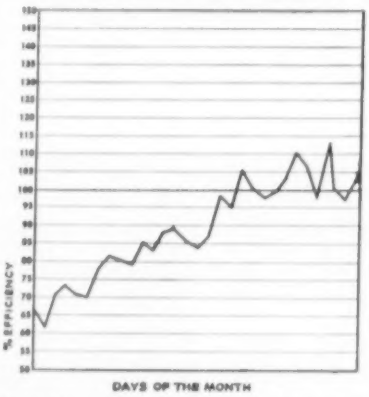
In order to appreciate these changes permit me to digress a few moments for some necessary background information.

Two years ago a firm of management engineers conducted a study of the laundry in an older section of the building.* Even with the then existing obsolete equipment, crowded working conditions, and inadequate work flow, the engineer assigned was able to reduce personnel from 30 to 26 by rescheduling laundry operations from a five-day week to a six-day week with half a crew working each Saturday, thus balancing the work load. This balanced work load still required each employe to work only 40 hours per week. The engineer was not primarily interested in work methods at the time because he knew that the laundry would be moved soon to a new location with a completely different set of working conditions.

In the transition from old to new laundry, the laundry manager was able to reduce personnel from 26 to 23 because of the new equipment. For example, the automatic folder requires only one operator where formerly two were needed.

*Management Study, Mod. Hosp. 84:65 (June) 1955.

GRAPH OF EFFICIENCY RATING



Graphic representation of improvement shown by operator in 30 days.

In approaching any problem several logical steps must be taken in definite sequence so as to achieve best results. The six-step approach which we used in our laundry study was:

1. Define the problem.
2. Collect all the facts.
3. Analyze the facts.
4. Design the best method.
5. Install this best method.
6. Follow-up, revise and control.

Step 1. Define the problem

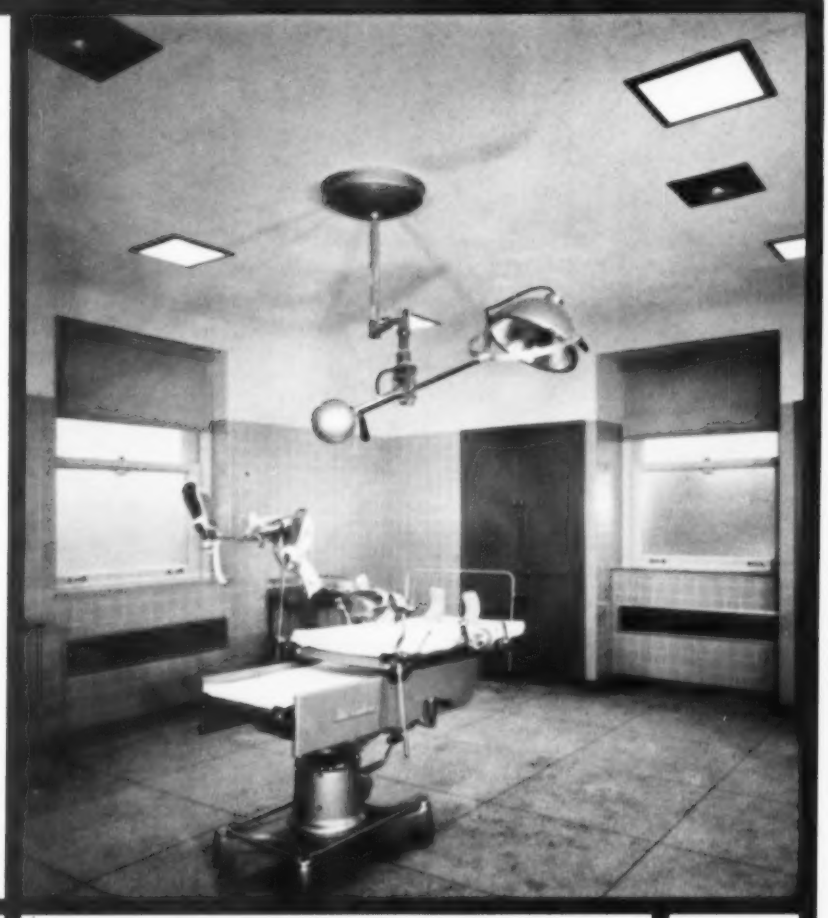
We defined the problem as: "Find the most economical methods of processing soiled linens through each of the various operations in the laundry so as to produce the highest quality finished linen in the least amount of processing time at the minimum cost."

Step 2. Collect all the facts

We began to collect all the facts by drawing a flow diagram of existing conditions. All soiled linens come first into the sorting room where they are thrown into a number of classification piles. Each pile is transferred to a rolling truck, moved onto a portable scale, weighed and moved to a storage area near the washing machines awaiting loading. After loading and subsequent washing they are moved to the extractor where they are loaded by means of an overhead hoist. After the excess water is extracted, the overhead hoist again lifts the load out of the extractor and over a portable rolling table where the load is dumped.

Each piece of damp wash must be removed from the rolling table and placed into rolling hampers. Thus the rolling table is released for use by the next load from the extractor. In the rolling hampers the uniform press work goes to the pressing units, the rough dry goes to the tumblers, and flatwork goes to the flatwork ironer,

Photos: A. R. Gilbert



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▲ To provide draftless air diffusion in the delivery room, All-Air High Velocity units are placed under the window. High velocity sound attenuation chambers with square diffusers are mounted in the ceiling. *Turn page for detail.*

In the nursery for premature infants, sound attenuation chambers with square air diffusers are mounted in the ceiling. *Turn page for detail.* ▼

▲ All-Air High Velocity under-the-window units are used in all private and semi-private patients' rooms. *Turn page for detail.*

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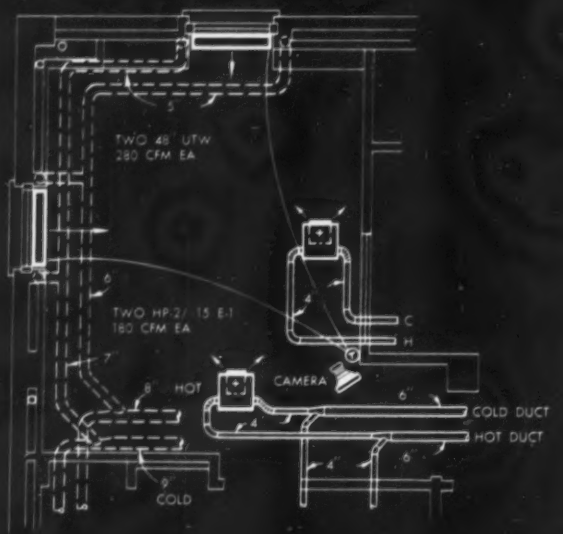
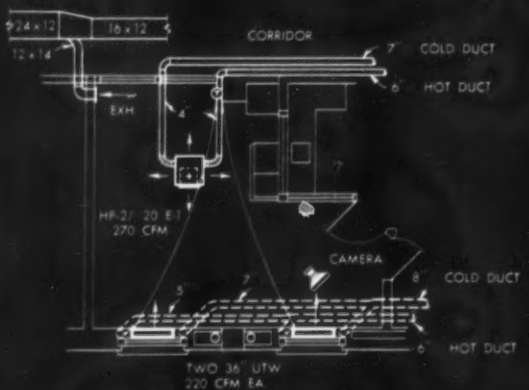
Delivery room



Patients' room

Premature Nursery



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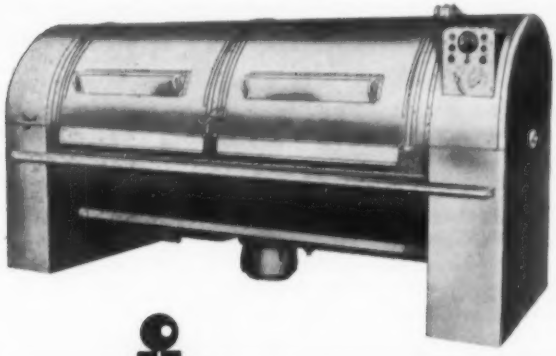
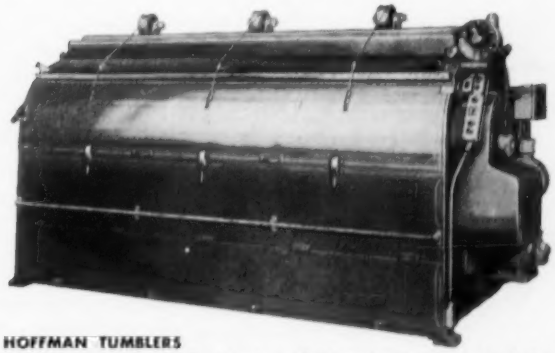


HOFFMAN LAUNDRY EXTRACTORS
Model shown is an Unloading Laundry Extractor which avoids manual handling of work, speeds production and saves manhours. Also, Hoffman Open-top Laundry Extractors in 40 and 48-inch basket diameters. Smaller Hoffman Extractors are the 17, 26, and 30-inch Steel Curb models. All three types assure you high-speed acceleration, powerful braking for quick stops and maximum extraction . . . truly unparalleled efficiency in their size and type ranges.



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ultimately, each of these three finishing processes ends in the linen room.

Step 3. Analyze all the facts

This step entails taking all the facts which have been accumulated and challenging every step of the original method. This is done by asking the following types of questions:

What is being done? What is necessary? What is unnecessary?

Why is this necessary? Why does the soiled linen have to be sorted? Why must it be weighed? Why must it be stored? Can we eliminate anything? Can we combine? Can we simplify?

Where must this be done? Where would it best be done? Should we sort in the sorting room or should we use the present storage room which is about the same size? Where must the uniform checker be located in relation to the pressing units and the linen room? Is it best that the checker stay where she is, or would it be better to move her closer to the presses and further from the linen room?

When must this be done? Should the order of rotation be changed? Should sorting be done, not in the sorting room, but after extraction? When should the linen chute be pulled? Should a definite schedule be maintained by the linen man or should he be assigned to use his own judgment in pulling the chutes?

IS SPECIAL SKILL NEEDED?

Who should perform this operation? Can a person of less skill be designated as washman? Who is best qualified to do the sorting? Should a man or woman perform this operation? Does it require a person with more or less skill to be a press operator?

How should this be done? Is this the correct sequence? Is this the correct method? Can there be a slight change in method, thereby resulting in a better flow of work? Will the work be more uniform? Will it be less fatiguing? Will it be more productive? How can we simplify all operations?

When this question approach was applied to each of the steps listed in our original product process chart, many suggestions came to the mind of the analyst. He immediately jotted down these suggestions in the form of written explanations or charts and diagrams and sketches so as not to omit any possibilities.

To clarify both the question approach and the suggestion list, let us use an example as applied to the sorting and the weighing operations. In applying the question approach, we found that there were two important basic considerations. These are as follows:

First, the soiled linen is to be sorted into several classifications so as to keep white linens separated from colored, heavy soil from light soil, flatwork and press work from tumble work. The laundry manager had established that eight classification sorts were necessary.

MAINTAIN PROPER WEIGHT

Second, a proper weight of soiled linen must be maintained in the washers. The three new 42 by 84 inch washers have a load capacity of 350 pounds each, or 175 pounds in each pocket. If this weight is exceeded considerably: (1) The equipment is overtaxed, running the chance of burned-out motors and bearings. (2) The soiled linen is inadequately washed, resulting in poor quality laundering with resultant chances of contamination if all soil is not removed properly.

If the weight of dry soiled clothes is considerably less than 175 pounds per pocket:

1. The equipment is not being used to best advantage, which means that more machine loads are needed per day to process a given daily weight of linen. This could present a problem after expansion is complete.

2. More water is used per pound of clothes washed. This is true because the washing formula sets the water level the same for each load requiring that formula. Thus, if less weight than that required is put into the washer, the volume ordinarily occupied by soiled linen is instead occupied by water. This is an additional expense, especially in the case of hot water.

3. More supplies are used per pound of clothes washed. Since the same weight or volume of supplies is added to an underweight load as to a regular load, the cost per pound of linen washed will be higher for the underweight load.

4. There is less chance of reaching desired quality. This is true because since more water is used per pound per load and the same volume or weight of supplies (such as soap, sour, bleach) is used for the underweight load as for the proper weight load, the concentration of supplies per

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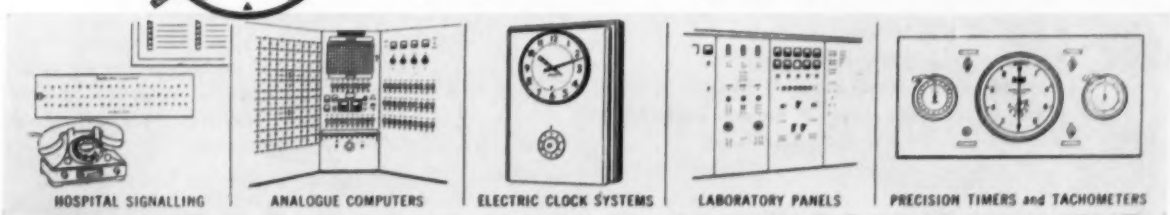

gallon of water is less, resulting in an insufficient action by the various supplies.

5. The pounding action of the washer on the linens results in abrasion of the linens being washed, thus materially reducing their life.

Therefore, these two basic factors are extremely important in the sorting room: (1) Eight different classifications must be sorted. (2) The proper weight of 175 pounds per pocket must be maintained for each pocket of the new washers for maximum efficiency of equipment, supplies and labor, and for the desired quality of processed linen.

By using the question analysis we found the conditions as outlined. Therefore we jotted down as many possible suggestions as to how to get the eight different classifications and the proper weight of 175 pounds per washer pocket. A few possibilities considered were as follows:

1. Design special bins that would be lined with a heavy canvas fixed at the front end but lying loose in the bottom and back of the bin and attached at the top by means of block and tackle with a rope near the sorting operator. When the desired classification is needed for the washer, the sorter operator would pull the rope, thus causing the canvas to become taut and flipping its contents into a prepositioned portable scale-inclined conveyor unit. The scale-inclined conveyor unit would then be moved to a point contiguous to an overhead conveyor whereby the proper weight of clothes would be automatically conveyed to the proper washer.

2. Use the existing storage room as a storage room for soiled linen with a horizontal belt conveyor leading from the room through the wall into the sorting room and then to the washers. The operator could sort in this room into bins positioned above the conveyor and, by means of slides and chutes, the proper classification would be shunted onto the conveyor at the proper moment, thus sending the soiled linen to the proper washer via the belt conveyor.

3. Sorting operator could stand on special platform located in the sorting room. The eight bins could be arranged in front of him, and when the desired classification is needed at the washing machine, he would trip a lever, thus dumping the contents of the bin onto a horizontal table. This table, built at a slight inclined angle, would shunt the soiled linen onto a permanently positioned scale. When the proper weight would be reached as determined by deflection of the scale platform, a micro-switch assembly would start an inclined conveyor which would convey the soiled linens to an overhead horizontal conveyor, and thus the soiled clothes would be sent to the proper washing machine.

4. Design a system of slightly inclined floor plates, whereon would rest regular 12 bushel trucks, such as are now used to transport soiled linen. The increasing weight would deflect the inclined floor plate till a microswitch would be tripped, thus closing an electric circuit and automatically flashing a signal light. The operator then would know the proper weight had been reached and he would remove the truck, replacing it with an empty one.

The same type of analysis was made every step of the way so that we would come up with the maximum number of possible suggestions for each of the various operations.

Step 4. Design the best method

Each of the recorded suggestions

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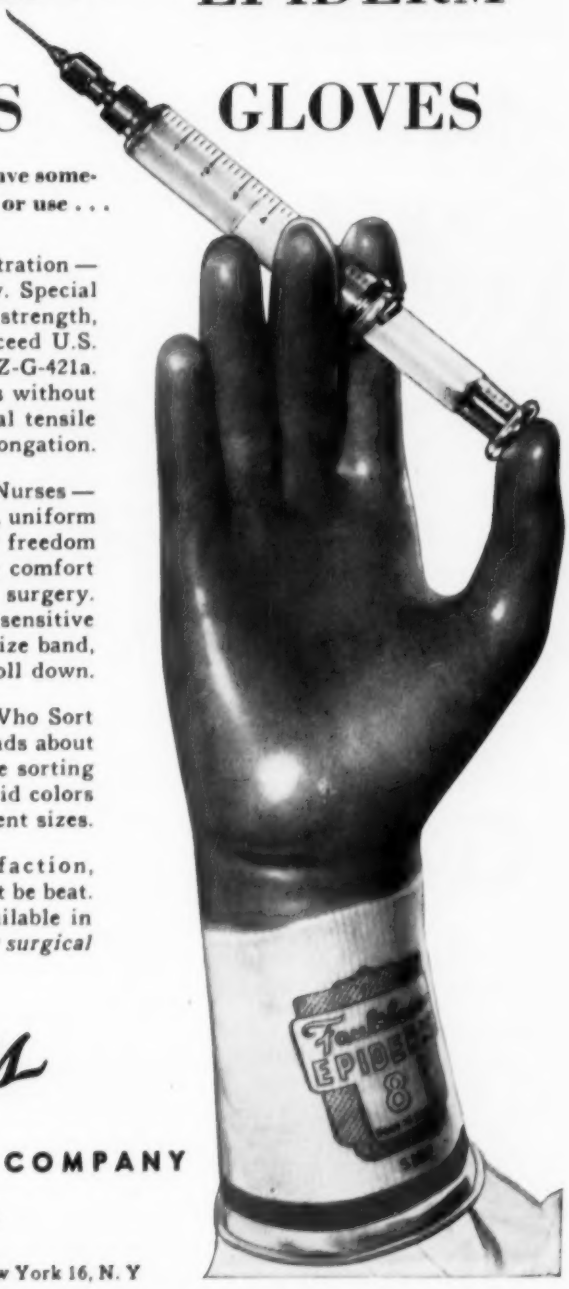

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$$\% \text{ efficiency} = \frac{\text{No. standard minutes production should have taken}}{\text{No. actual minutes on job}} \times 100$$

100% efficiency represents the efficiency of an average worker performing work under average conditions.

must be weighed in the light of cost, hazard, control and psychological factors. Many of the suggestions made during the course of the study proved to be feasible from the methods application standpoint but not feasible in relation to one or more of the four factors. The predominant factors in our study were related to economy, or cost. *How much would it cost to install the new system and how much would we save by using it?*

Of the four suggestions in relation to the sorting operation listed in Step 3, the last (using micro-switches and flashing lights) was adopted as the most feasible solution. Some of the other changes that were made are:

Five specially designed tables were built for dumping of extractor loads and shaking operations. These tables eliminated much duplicative handling of individual pieces of wet wash.

Uniforms are hung on racks instead of folded, thus eliminating hand operations and travel to old uniform room.

Complete layout change of linen room based on functional needs eliminates about 50 per cent walking of the linen room attendant.

Step 5. Install best method

We are currently engaged in making the methods changes outlined in this report. At the same time we have been able to reschedule the personnel, and the entire laundry is now back on a five-day operation. The workers prefer this five-day week to a six-day operation of the laundry, since they can now plan on most of their Saturdays being free. The work load again has been brought back into balance and in the process we have reduced the required number of operating personnel from 23 to 19.

Step 6. Follow-up, revise, control

As an example of this step, the laundry manager had questioned the validity of the findings on the press operation. We had four press operators, but the engineer had established that for present production requirements three press operators were sufficient. Thus, further engineering time studies were developed for the existing methods and kinds of pressing, and standard times were established for 16 different kinds of work. The study proved quantitatively that three pressers were sufficient for our present production needs.

A "Laundry Weekly Press Record" form is a control tool to be used by the laundry manager. Each day he computes for each presser operator her percentage of efficiency. Percentage of efficiency is defined by the formula at the top of the page.

A word of caution: Only an experienced time study analyst should take time studies with the purpose of establishing standard times per piece. Standard time includes a rating or leveling factor which adjusts the speed of any operator to that of an *average* worker. In addition, standard time includes a number of allowances, such as for personal, fatigue, rest, flow of work, and unavoidable delays.

The second control tool was a graphical representation of the daily efficiency ratings of each operator. An example for one operator for 30 days is shown in the graph on Page 128. Note that the graph has an upward sweep signifying that the operator improved toward the end of the month. Undoubtedly the laundry manager began taking remedial action early in the month and this accounted for the increased productivity and consequent increased efficiency.

An additional control tool was the development of complete job descriptions for all jobs in the laundry.

By applying the scientific approach to problem solving we have been able to establish improved work methods in our new laundry. This has resulted in a number of tangible savings and improved working conditions.

By no means can we assume that our work is completed. Changing patient care technics and advancing technology will require management engineering studies on a continuing basis. Only if we keep alive a questioning attitude will we be able to solve this continual problem: "Find the most economical methods of processing soiled linens through each of the various operations in the laundry so as to produce the highest quality finished linen in the least amount of processing time at the minimum cost."

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HOUSEKEEPING

They Don't Hoard Linen Any More

An ingenious cabinet arrangement at Swedish Hospital, Seattle, permits linens for patients' rooms to be stored in the room instead of in central closets—and the cry of "not enough linen" is silenced

HAROLD F. OSBORNE

WHEN the trustees of the Swedish Hospital in Seattle were discussing their ideas for a new 78 bed wing, they told the architects: "We want the patients' rooms to look as little like the traditional hospital room as is consistent with the best of hospital care."

They got them.

But the architects, by way of a bonus in the same package deal, also provided an arrangement that:

1. Eliminates central linen storage on each of the 26 bed nursing stations in the new wing.

2. Provides the effect, in use, of a private bath and shower for every patient, with no more utilization of space than an ordinary floor of predominantly semiprivate rooms without baths would require.

The secret of the design is in a compact five-sided core, containing toilet and shower, which separates each pair of rooms at the partition line.

The perimeter of each pentagon is filled with built-in cabinets, designed to hold every item needed by the room during its occupancy—pillows, bedpans on racks, the patient's toilet articles, and two days' supply of linen.

In each room a stainless metal lavatory, beneath a lighted mirror, also is built into the space saving unit.

The pentagonal shape of the unit was hit upon by the architects, Naramore, Bain, Brady and Johanson. It was dictated, Ernest E. Andrew, supervising architect, explains, by functional planning and the need for two bathroom doors, one opening into each room.

The outcome was a bathroom in which a patient occupying the bathroom locks both doors by throwing one ingeniously designed bolt. The same action also turns on a light over each door, indicating clearly to the occupants of the three other beds that the room is occupied.

The lock also is constructed so that an occupant cannot open either door without unlocking the other one; when he returns to his bed, he cannot forget to open the door to the communicating room.

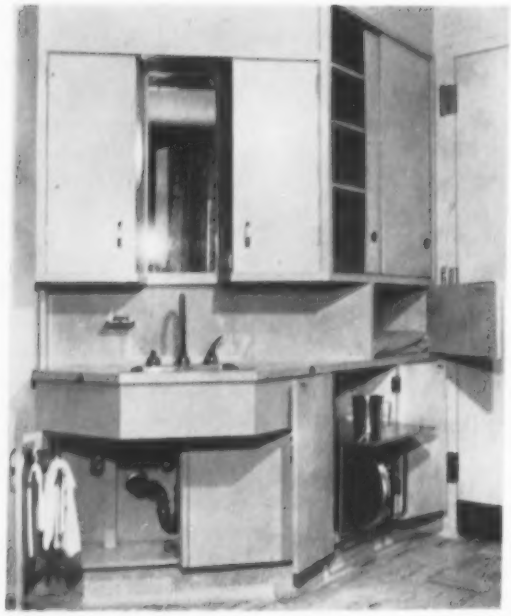
Although the doors lock only from the inside, nurses can open any bathroom—in the event a patient faints, for example—with an emergency tool something like a skate key, which is kept "hidden" in the same spot in every room.

The cabinetwork concealing each bathroom is of polished birch, blending with the pastel tints of the walls and draperies.

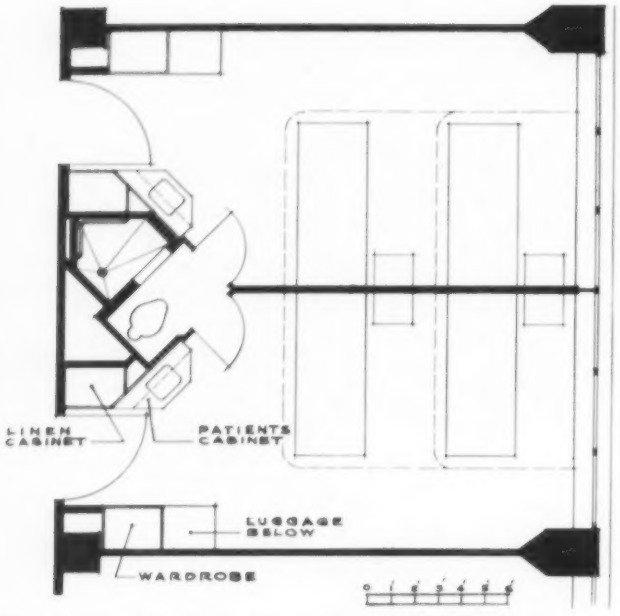
Another wall cabinet, opposite the bathroom core, provides the additional drawers and built-to-fit spaces needed for the patient's clothing, luggage and other belongings.

Only movable furniture in the

Door at left leads to toilet and shower serving two semiprivate rooms; an ingenious lock assures each of the four patients privacy. Counter top (right) was designed to enhance display of flowers by use of mirror.



Linen storage cabinets, right, in each room eliminate the need for central linen storage on the floors.



Plan shows how pentagonal space saving bathroom has been installed at partition line between each pair of semiprivate rooms.

rooms are the beds, the bedside stands, and floor lamps. Even folding chairs for visitors are "built in," inasmuch as they hang up in a special space on the cabinet wall when not in use.

"With less furniture to move around, we are confident there will be less abuse and our upkeep costs will be substantially lower," says Administrator Ray Farwell.

"The cabinets take up less room than furniture would, saving space for other purposes," he adds. "Our nursing and housekeeping staffs like the arrangement, too, because there is a place for everything, yet nothing is out in the way."

Perhaps the most revolutionary feature of the arrangement, both Mr. Farwell and Mr. Andrew believe, is in the provision for the storing of linen for each room in the room itself.

Only a small emergency cabinet is kept at each nursing station for general use. It may go for days without being touched.

The arrangement came about coincidentally with a reorganization of the laundry service for the whole hospital, including both old and new wings, which Mr. Farwell had instituted after conferences with John Horrigan, laundry supervisor.

"Each floor now receives a predetermined quota of linen, set by the nursing staff, each day. Unused linen is taken back to the laundry," says Mr. Farwell.

"The plan has ended the constant complaints from the nursing staff that there was never enough linen. It has eliminated the need of their trudging down to the laundry and standing in line for new sheets.

"But most of all, it has wiped out the hoarding on each floor," says Mr. Farwell. "We were amazed at the amount of linen that came out of hiding once it was obvious that there always would be a supply delivered each day—we had to buy far less new linen than we had thought would be necessary."

Mr. Horrigan confirms the smoothness of the operation. Now his department delivers linen, in service carts, to each floor daily. In the older sections of the hospital, a laundryman fills the linen closets with the quota allotted for it.

In the new wing, the laundryman leaves a full cart at each nursing station. Nurse's aides make up "kits" of linen and place them in the cabinets in each room. That way, laundry personnel does not enter the patients' rooms, Mr. Horrigan notes.

"It saves our time in the laundry," he adds. "I wish we could have the same system throughout the hospital."

The linen distribution arrangement has brought one of the few dissents, however, to the general approval given the new wing's facilities.

Miss Jackie Tollett, a head nurse, says: "This plan works out very well in the mornings, when we need linen for the rush of bedmaking. But it does take more of the nursing time during the day to make up the kits and place them in the room."

Miss Tollett observed that nurses have two other criticisms of the cabinet-and-bath arrangement on the new wing.

"It would have been better if the cabinets for linen and bedpans had been placed on the other side of the corridor door," says Miss Tollett. "As it is, the nurse has to shut the outside door in order to get behind it to obtain a bedpan or replace a draw sheet.

"Sometimes someone else enters the room just as she is behind the door and the nurse gets a bump."

The fact that each bathroom door has a louvered panel for ventilation, she adds, makes noise in one room somewhat more apparent in the communicating room than would be the case with solid partitions.

Mr. Farwell concedes this. But, he says, "We think it's a small price to pay for everything else we got—a cheerful, functional, uncluttered arrangement that gives the patient in a semiprivate room more comfort and convenience than we could ever offer him before."

Identical bathrooms and cabinets are provided, he observes for a clincher, in the de luxe suites and the private rooms in the new wing.

A Guide to Budget Management

(*Continued From Page 74*)

An additional refinement in the direct expense type of budgeting may be found in the dietary department. The administration of the hospital may make a predetermination on the average expenditure for raw food per patient and employe meals for the coming fiscal year. This raw food cost, then, becomes the dietary department's guiding light. The dietitian can, through precontrol, determine that no more or less than this amount will actually be expended. As a control, raw food cost is computed every week showing the daily raw food cost for that period.

An adjustment can be made by the dietitian either upward or downward, depending upon the results of this cost report. This phase of the management budget then becomes a method of control for the department head.

In the predetermination of the raw food cost, as in other expenses, it is important to consider market trends whether by total or by classification of items. For example, food represents a large item of expense and therefore a general market rise will reflect itself as a large difference in this item of expense.

Miscellaneous Expenses

Miscellaneous expenses are also broken down by type for each department and if possible placed in the months in which they will occur. (See Exhibit 15.)

Repairs and Maintenance Expenses

Anticipated repairs are requested from each department head prior to the computation of final budget. Thus, past experience plus anticipated repairs provides for a basis to estimate repair and maintenance expenses. (See Exhibits 15 and 17.*)

Social Security Expenses

This expense item is calculated monthly on the basis of the salary budget. (See Exhibit 15.)

Annuity Expenses

When this expense is applicable, it is calculated on the basis of those employes eligible at the beginning and during the fiscal year. (See Exhibit 15.)

Expense Summary

The final step in budgeting "other expense items" is to prepare an expense summary. This is a listing, by departments, of the monthly expenditures for "other expenses" for the budget year. (See Exhibit 15.)

STEP 3—NONOPERATING EXPENSES

Nonoperating expenses are also computed on a monthly basis and added to the final budget. (See Exhibits 16 and 19.*) Such items of expense would include:

1. Interest on notes payable
2. Legal fees
3. Investment advisory fees
4. Pensions
5. Rental on leasehold
6. Fund raising expenses

STEP 4—DEPRECIATION

It is recognized by most authorities in the hospital field that depreciation for buildings and equipment is a regular hospital operating expense.

The American Hospital Association suggests that the "straight-line method" of computing depreciation is probably the most practical for hospital purposes. "Under this method, the cost or other basis of property, less its estimated salvage value, is deducted in equal annual installments over a period of its estimated, useful life. Ordinarily, the depreciation deduction is computed by applying a depreciation rate expressed as a percentage to the cost or other basis to be recovered, but it also may be computed by dividing that cost or other basis by the estimated useful life." (See Exhibit 19.*)

Exhibit 15—XYZ Hospital Budget Year Ending 19—

Expense Summary

	June	July	August
Administration			
Salaries			
Director's division	$3,600.00	$3,700.00	$3,700.00
Business office	4,500.00	4,790.00	4,980.00
Switchboard	2,100.00	2,200.00	2,150.00
Personnel	1,000.00	1,100.00	1,150.00
Purchasing	1,025.00	1,200.00	1,150.00
Sundry	625.00	600.00	525.00
Supplies			
Forms	700.00	700.00	700.00
Sundry	100.00	100.00	100.00
Miscellaneous			
Collection expenses	125.00	125.00	125.00
Telephone & telegraph	3,500.00	3,500.00	3,500.00
Insurance	990.00	990.00	990.00
Travel	25.00	25.00	25.00
Postage	190.00	190.00	190.00
Auditing	150.00	150.00	150.00
Dues & subscriptions			100.00
Sundry	230.00	230.00	230.00
Repairs & maintenance	50.00	50.00	50.00
Social security	230.00	230.00	230.00
Annuity Total	225.00	225.00	225.00

Exhibit 16—XYZ Hospital Budget Year Ending 19—

Nonoperating Expenses

	June	July	August	September
1. Interest on notes payable	$ 600.00	$ 600.00	$ 600.00	$ 600.00
2. Legal fees			500.00	
3. Investment advisory fees		400.00		
4. Pensions	100.00	100.00	100.00	100.00
5. Rental on leasehold	1,500.00	1,500.00	1,500.00	1,500.00
6. Fund raising expenses	400.00	400.00	400.00	400.00
Total	$2,600.00	$3,000.00	$2,100.00	$2,600.00

*To be published in Part 3, August 1956 issue.

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NEWS DIGEST

Louisiana Association Urges Scholarships for Nurses . . . Hutchins Named Head of Michigan Association . . . Middle Atlantic States Elect Officers . . . A.N.A. Continues Opposition to Bolton Bill . . . Residency Appointments Announced

Louisiana Group Urges Nursing Aid; Dr. John MacKenzie Is President-Elect

NEW ORLEANS.—The Louisiana Hospital Association voted at its annual meeting here May 23 to 25 to ask the state legislature to pass a bill, proposed by the Louisiana Nurses' Association, which will provide scholarships for postgraduate education in nursing administration and teaching methods.

The unanimous vote to support the Louisiana Nurses' Association in getting this legislation passed was the result of a report from Raymond C. Wilson, president of the association, pointing out the serious shortage of nurses who are properly prepared to assume supervisory or administrative posts in hospitals or to handle teaching assignments. The proposed legislation would provide $100,000 annually to give scholarships to graduate staff nurses for the purpose of taking postgraduate work in administration and teaching. The bill proposes that the governor appoint a commission to administer the program. Recipients of scholarships would agree in writing to return to or remain in Louisiana to pursue administrative or teaching work for not less than two years following completion of the postgraduate work.

Delegates at the opening business session also voted unanimously to support a bill to increase medical coverage under the workmen's compensation act and to amend the present lien law so as to extend its benefits to all voluntary hospitals.

Herman Herold, new president of the association and chairman of the council on government relations, urged administrators and hospital trustees to get acquainted with their state senators and representatives and to be sure that these elected people understand the problems facing hospitals. He reported that the University of Louisiana has offered to cooperate with the state hospital association in providing faculty and facilities for two hospital administrative institutes each year.

Louisiana officers (l. to r.): Dr. John MacKenzie, president-elect; Raymond C. Wilson, retiring president, and Herman Herold, incoming president.

Dr. Faye Abdellah, research consultant, Division of Nursing Resources, U. S. Public Health Service, and Marion Souza, supervisor of nurse education, State Department of Education, Baton Rouge, discussed a statewide survey made in Louisiana of nursing needs and resources.

Dr. Abdellah said the survey shows that, in general, Louisiana nurses are happy with their work. They are anxious, however, "to find ways of reducing their heavy case assignments and they would like to be given more opportunity of being with patients."

Miss Souza reported that only 14 per cent of the professional nurses on the faculties in collegiate schools of nursing are prepared for their jobs.

In his report to the association, Jesse Bankston, executive secretary, stated that medical and hospital care limitation of $1000 on compensation cases is totally inadequate, and that the state association is trying to get this limit raised to $2500. He pointed out that the State Association of Manufacturers and Contractors is opposing this legislation and, in order

(*Continued on Page* 168)

Hutchins Will Head Michigan Association

DETROIT.—Ralph C. Hutchins, superintendent of Gratiot Community Hospital, Alma, was named president-elect of the Michigan Hospital Association at the annual meeting of its house of delegates here, June 11. Dr. A. C. Kerlikowske, director of the University Hospital, Ann Arbor, was installed as president, succeeding Mildred Riese, R.N., superintendent of Children's Hospital, Detroit. Dr. Kerlikowske is former head of the American College of Hospital Administrators.

In addition, the house of delegates elected the following officers: first vice president, Bentley Frederick, administrator, Little Traverse Hospital, Petoskey; second vice president, Sister Mary Evelyn, administrator, Borgess Hospital, Kalamazoo; treasurer, Frederick S. Burd, administrator, Holland City Hospital, Holland.

Maine Association Reelects All Officers

ROCKLAND, MAINE.—Members of the Maine Hospital Association meeting here June 12 and 13 reelected all of its incumbent officers, as follows: president, Neil H. Bunker, Mount Desert Island Hospital, Bar Harbor; president-elect, Lawrence M. MacDougall, Eastern Maine General Hospital, Bangor; secretary, Matthew I. Barron, Portland City Hospital, Portland, and treasurer, Sister Mary Mercy, Mercy Hospital, Portland.

Two important actions were taken by unanimous vote of the membership. The first was a resolution to send a telegram to Rep. Frances P. Bolton (R.-Ohio) approving the Bolton Bill and pledging her the association's support.

A second resolution urged that state and federal governments should reimburse hospitals for the costs incurred in setting up emergency facilities and materials to be used for civil defense and major disasters.

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Accreditation Gets "A" From A.M.A.

(*Continued From Page 52*)

ties be available for teaching purposes."

To make certain there could be no mistaking its oppposition to corporate practice, however, the house, on motion proposed from the floor while the report was under consideration, appended a paragraph at the end stipulating that "Nothing in this report is meant to condone the corporate practice of medicine or policies which result in the diversion of physicians' fees to a corporation or governmental agency."

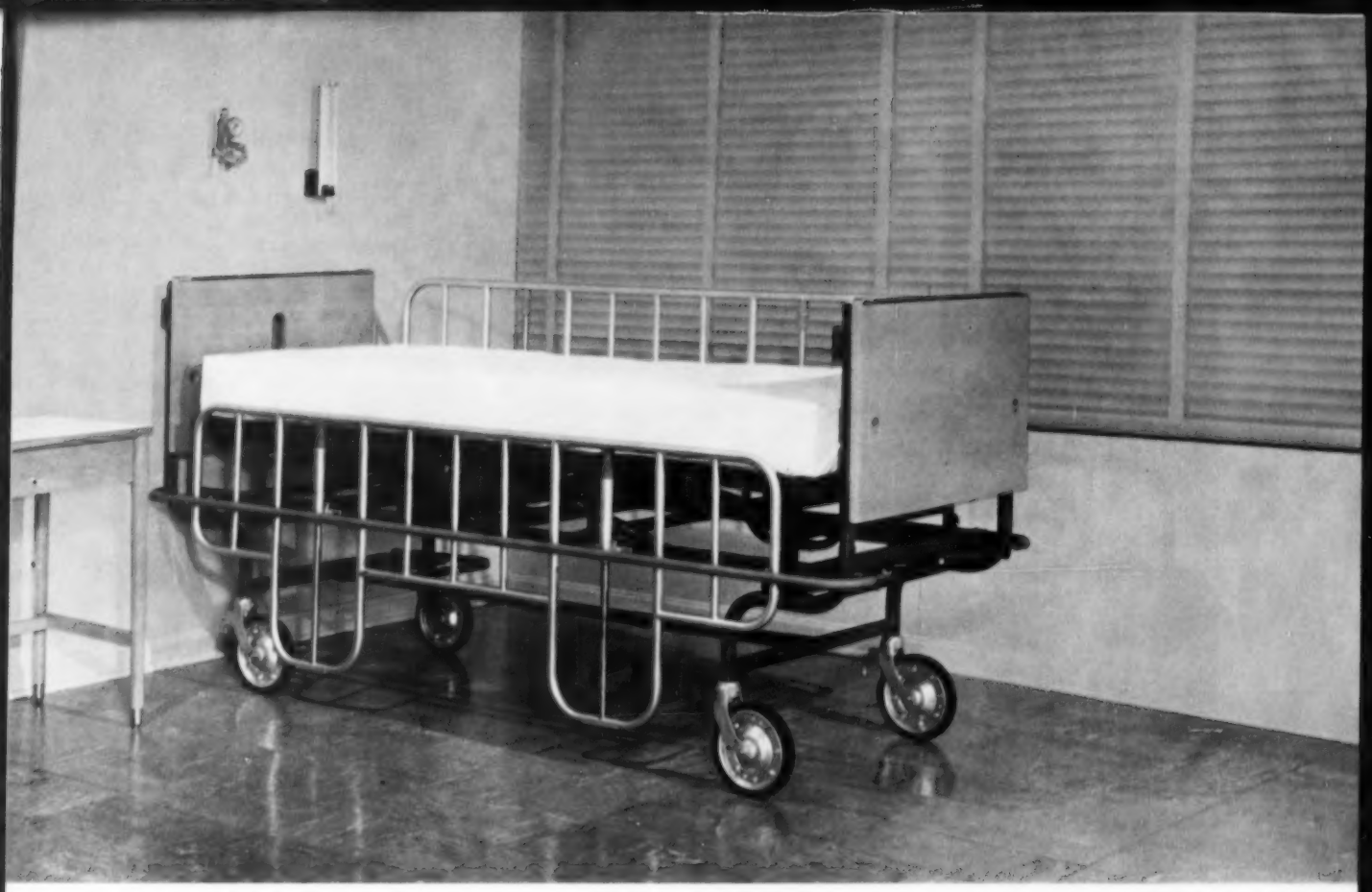
In another session, the House of Delegates approved A.M.A. participation in the Evaluation Service for Foreign Medical Graduates, a joint program with the American Hospital Association, Federation of State Medical Examining Boards, and Association of American Medical Colleges, aimed at devising an effective mechanism for measuring educational attainment in the absence of specific knowledge of the educational background of foreign-trained physicians.

"This mechanism should provide hospitals with pertinent information regarding the medical qualifications of foreign-trained physicians seeking positions as interns or residents," the Council on Medical Education and Hospitals said in its report to the house. "It should not interfere with the hospital's privilege of making its own selection among qualified physicians, nor should it serve as a substitute for or interfere with the normal licensure procedures of the various state boards."

As explained by the council, the Evaluation Service is designed to establish two principal criteria in regard to the foreign-trained physician: (1) that he is a graduate of a bona fide medical school; and (2) that, as nearly as can be measured, he has reached a level of educational attainment comparable to that of students in American schools at the time of graduation.

The criteria will be established by evaluation of the foreign-trained physician's medical credentials in view of predetermined standards, and examination of the physician for factual knowledge of medicine, it was explained.

"If this program is widely accepted," the council report said, "foreign-trained physicians seeking further training in the United States will not be able to find positions offering such experience until they have successfully completed all phases of the program."



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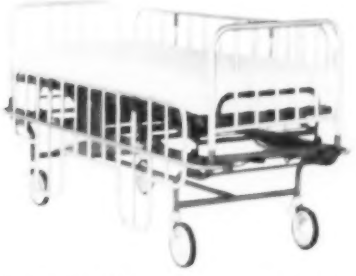

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For further details of these multi-purpose beds write for Procedure Manual No. 2, written by Alice Price, R.N., M.A., Nurse Consultant for Hill-Rom Co. and author of "The Art, Science and Spirit of Nursing."

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Complete information on either or both of these high-low beds will be sent on request.

Safety Sides—A New Safety Measure

by Alice L. Price, R. N., M. A.

author of "The Art, Science and Spirit of Nursing"

This Procedure Manual explains in detail how to effectively use Safety Sides to prevent bed falls and to avoid serious injury to patients. Copies for Student Nurses and for the Graduate Nurse Staff will be sent on request.

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Middle Atlantic States Meet, Name Officers

ATLANTIC CITY, N.J.—Pennsylvania, New Jersey, and New York hospital associations elected officers during the eighth annual meeting of the Middle Atlantic Hospital Assembly here, May 16 to 18. State association officers elected are:

PENNSYLVANIA: president, C. Robert Youngquist, administrator, Sharon General Hospital, Sharon; first vice president, James C. Kirk, administrator, Pottsville Hospital, Pottsville; second vice president, Mother M. Michael, Misericordia Hospital, Philadelphia; treasurer, Joseph W. Bishop, administrator, Hahnemann Hospital, Scranton; executive secretary, John F. Worman, Harrisburg.

NEW JERSEY: president, Cora E. Gould, administrator, New Jersey Orthopaedic Hospital Unit, Orange; president-elect, Ralph E. Vannozzi, administrator, Bridgeton Hospital, Bridgeton; vice president, Nelson R. Henson, administrator, Englewood Hospital, Englewood; treasurer, Dr. Abram L. Van Horn, medical director, Kate Macy Ladd Convalescent Home, Far Hills; executive director, J. Harold Johnston.

NEW YORK: president, Dr. Ambrose P. Merrill, director, St. Barnabas Hospital, New York; first vice president, Lawrence Bradley, director, Genesee Hospital, Rochester; second vice president, Carlton P. Shannon, administrator, House of the Good Samaritan, Watertown; secretary, Theodore F. Childs, superintendent, Lenox Hill Hospital, New York; treasurer, Moir P. Tanner, director, Children's Hospital, Buffalo; executive director, Charles M. Royle.

A.N.A. Opposition to Bolton Bill Continues

NEW YORK.—Despite an 11th hour attempt to modify its stand, the American Nurses' Association's opposition to the Bolton bill continues. Its house of delegates did not reverse its stand of overwhelming opposition to H. J. Res. 485 at its final convention session in Chicago, as reported in our last issue.

What happened was this: A nondelegate, R. Louise McManus, director of the division of nursing education at Teachers College, Columbia University, introduced a new proposal lacking features that nurses found controversial in the Bolton bill. It urged the A.N.A. to take the initiative in seeking assistance from the A.M.A., the A.H.A., the A.P.H.A., the National League for Nursing, other organizations, and the public in making a study of patients' problems and public needs for adequate health care, including (but not limited to) nursing services.

The A.N.A. president proposed an amendment modifying the proposal, which, as it was approved by the house of delegates, recommends that the A.N.A. board study the feasibility of such a project.

Plan Integrated Hospital

CHICAGO.—A 100 bed, racially integrated, nonprofit hospital is being planned by the board of directors of the Lake Meadows Hospital Corporation, Chicago. The hospital, which will occupy the building formerly used by Chicago Memorial Hospital, will select its personnel on the basis of merit and qualification without regard to race, creed or color, said Leo A. Lerner, chairman of the board of directors of the hospital. The hospital will serve all Chicago and will not be limited to South Side patients.

S.A.M.A. Survey Reveals Intern Dissatisfactions

CHICAGO.—A recent survey of 1450 interns, conducted by the Student American Medical Association, was reported on at the S.A.M.A. convention here last month. The survey revealed that most interns believe that few hospitals offer internships that give adequate preparation for general practice.

The interns believe their hospital's internship program does not have teaching as its primary purpose. They also are dissatisfied with the pay scale and the setup for receiving needed financial assistance.

More than 90 per cent of the interns, however, think the intern year should be continued. A small proportion suggested that a fifth year of medical school replace the intern year.

The S.A.M.A. also passed a resolution on intern salary scales, stating that "educational benefits must be made economically possible." A standing committee will determine which hospitals and institutions meet the ideal minimum in educational advantages.

Northwestern Announces Residency Appointments

CHICAGO.—Northwestern University announces the following appointments to administrative residencies in hospitals for students who have completed one year of academic work and who plan to qualify for master's degrees in hospital administration in June 1957:

James Anderson to Memorial Hospital of DuPage County, Elmhurst, Ill.; Gordon Boughton to Community Hospital, Indianapolis; La Verne Burner to Victory Memorial Hospital, Waukegan, Ill.; Peter Buttaro to Louis A. Weiss Memorial Hospital, Chicago; Thomas Byram to Baylor University Hospital, Dallas; Maurice Coffee to Lankenau Hospital, Philadelphia; Charles Cooper Jr. to University of Texas Medical Branch Hospitals, Galveston, Tex.; Neil Cooper to Eastern State Hospital, Knoxville, Tenn.; Adam

For photographs of graduating classes, see Pages 152 to 156

Coutts to Virginia Mason Hospital, Seattle; Joseph Davis to Fairview Park Hospital, Cleveland; Lawrence Davis Jr. to White Cross Hospital, Columbus, Ohio; John Devins to the Youngstown Hospital Association, Youngstown, Ohio; Paul Donnelly to Grant Hospital, Chicago; Jerry Durr to University Hospital, Jackson, Miss.

Douglas Eitel to North Carolina Baptist Hospital, Winston-Salem, N.C.; John Erlman to Malden Hospital, Malden, Mass.; Mary Finger to Hurley Hospital, Flint, Mich.; Edgar Furie to Jewish Hospital, Cincinnati, Ohio; Joe Greathouse Jr. to University of Louisville Medical Center, Louisville, Ky.; Donald Hansen to Bismarck Hospital, Bismarck, N.D.; Elmer Harvey to Methodist Hospital, Indianapolis; Joseph Hutchinson to Baptist Memorial Hospital, Jacksonville, Fla., and Theodore Johnson to Highland Park Hospital, Highland Park, Ill.

Harold King to Swedish Hospital, Seattle; Warren Lenz to University of Louisville Medical Center, Louisville, Ky.; Willard Leuthard to Herrick Memorial Hospital, Berkeley, Calif.; Rodrigo Moreno to Brackenridge Hospital, Austin, Tex.; Marie Oling to Silver Cross Hospital, Joliet, Ill.; Hansel O'Quinn to Baptist Hospital, Alexandria, La.; Gladys Post to Indiana University Medical Center, Indianapolis; Jaime Proano to Knickerbocker Hospital, New York; Maurice Shaw to Methodist Hospital, Lubbock, Tex.; George Skomsky to Auburn Memorial Hospital, Auburn, N.Y.; Victor Sledge to Baptist Hospital, Nashville, Tenn.; David Smith to Shannon West Texas Memorial Hospital, San Angelo, Tex.; Richard Stainback to Christ Hospital, Cincinnati.

Billy Talbert to St. Luke's Hospital, Chicago; Richard Thal to North Mississippi Community Hospital, Tupelo, Miss; William Van Slyke to Robert Packer Hospital & Guthrie Clinic, Sayre, Pa.; Roland Wilpitz to Santa Barbara Cottage Hospital, Santa Barbara, Calif.; Dov Wolotsky to Beth Israel Hospital, New York.

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University of Minnesota Announces Residencies

MINNEAPOLIS.—Students in hospital administration at the University of Minnesota have been assigned to residencies as follows:

Donald F. Andrews to Bethesda Hospital, St. Paul; J. Richard Arnzen to Rhode Island Hospital, Providence, R.I.; Paul C. Balcom to Johns Hopkins Hospital, Baltimore; George H. Cowen Jr. to Baylor University Hospital, Dallas; Lloyd F. Detwiller to University of California Medical and Research Center, Los Angeles.

Roger G. Dvorak to Rochester Methodist Hospital, Rochester, Minn.; Bruce E. Fischer to Syracuse Memorial Hospital, Syracuse, N.Y.; Robert J. Fitzsimmons to U.S. Public Health Service Hospital, New Orleans; Gerard W. Frawley to University of Minnesota Hospitals, Minneapolis; Herbert L. Fromm to St. Barnabas Hospital, Minneapolis; Alan M. Gilbert to Strong Memorial Hospital, Rochester, N.Y.; Elbert E. Gilbertson Jr. to Minneapolis General Hospital, Minneapolis.

Andrew A. Hain to San Jose Hospital, San Jose, Calif.; Peter S. Haviland to University of Kansas Medical Center, Kansas City, Kan.; John R. Jefferies to Stormont-Vail Hospital, Topeka, Kan.; Robert L. Jepsen to Memorial Hospital of South Bend, South Bend, Ind.; Edward R. Lynn to Abbott Hospital, Minneapolis; William H. Maloy to Highland Hospital, Rochester, N.Y.; Robert G. Michaels to Mount Sinai Hospital, Minneapolis; Clarence W. Palmateer to St. Luke's Hospital, Duluth, Minn.; Mark H. Tibbetts to St. Luke's Hospital, Milwaukee; Harold V. Weed to Charles T. Miller Hospital, St. Paul; Frederick R. Wolf to Swedish Hospital, Minneapolis; Donald F. Zuercher to Fairview Hospital, Minneapolis.

St. Louis Announces Residency Appointments

ST. LOUIS.—St. Louis University announces the following residency appointments for members of the 1956 graduating class in hospital administration:

Sister Daniel Marie McCabe, C.S.J., to St. Vincent's Hospital, New York; Sister Marie Finbarr Twohig, O.S.F., to St. Mary's Hospital, Waterbury, Conn.; Sister M. Scholastica Caufield, R.S.M., to St. Joseph's Hospital, Syracuse, N. Y.; Sister Mary Margareta Gall, D.D.R., to Sacred Heart Hospital, Yankton, S. D.; Sister M. de Paul Maas, C.S.J., to St. Mary's Hospital, San Francisco; Sister M. Calasantia Radzilowski, C.S.S.F., to St. Joseph's Mercy Hospital, Ann Arbor, Mich.; Sister Grace Marie Hiltz, S.C., to St. Vincent's Hospital, New York.

Sister Marybelle Leick, O.S.B., to St. Joseph Mercy Hospital, Pontiac, Mich.; Sister Emilene Pfister, S.S.J., to Mercy Hospital, Baltimore; Sister Madeleine Sophie Hebert, M.S.C., to Gill Memorial Hospital, Steubenville, Ohio; Sister Gertrude Schwager, F.C.S.P., to St. Francis Hospital, Pittsburgh; Sister M. Theophane Machan, C.S.F.N., to St. Vincent's Hospital, Indianapolis; Sister M. Consolata Pousson, C.D.P., to Good Samaritan Hospital, Dayton, Ohio; Sister Susanna Spalding, C.S.J., to St. Joseph Mercy Hospital, Pontiac, Mich.; Sister M. Patricia Aidan Lynch, C.S.J., to St. Joseph's Hospital, Paterson, N. J.; Sister Mary Beatrice McMahon, C.S.J., to St. Francis Hospital, Pittsburgh.

Sister Helen Kelley, D.C., to Providence Hospital, Detroit; Sister Josephine Aitchison, D.C., to DePaul Hospital, St. Louis; Sister Anne William Rickle, D.C., to Sisters of Charity Hospital, Buffalo, N. Y.; Sister Mary James McGloin, D.C., to St. Mary's Hospital, Evansville, Ind.; Sister M. Cyprian Gmeinwieser, C.S.J., to Queen of Angels Hospital, Los Angeles; Robert A. Biermann, to Holy Cross Hospital, Chicago; David DeBacker to St. Joseph's Hospital, Fort Worth, Tex.; Edward J. Fitzgerald to City Hospital, St. Louis.

Richard D. O'Hallaron to City Hospital, St. Louis; Thomas J. Underriner to Providence Hospital, Seattle; Sister Mary Humilia Cocot, C.S.F.N., to St. Joseph's Hospital, Phoenix, Ariz.; Sister M. Anne Veronica Coffey, O.S.F., to St. Francis Hospital, Hartford, Conn.; Ruth A. Kleppisch to Baptist Hospital, Pensacola, Fla.; Sister Mary Columba Kohler, I.H.M., to St. Mary's Hospital, San Francisco; John Malcom Randall to Veterans Administration Hospital, St. Louis; Sister Mary Ursula Stepsis, C.S.A., to St. Francis Hospital, Hartford, Conn.

University of Chicago Lists Residencies

CHICAGO.—Students who have completed the academic portion of the course in hospital administration at the University of Chicago have been assigned to the following administrative residencies. Positions other than administrative residencies are indicated.

Harold Autrey to University Hospitals, Cleveland; Gordon Beaty to Seaside Hospital, Long Beach, Calif.; John Deans to the position of assistant superintendent, City Memorial Hospital, Winston-Salem, N. C.; John Griffith to Strong Memorial Hospital, Rochester, N. Y.; Richard Malone to the position of assistant administrator, Baton Rouge General, Baton Rouge, La.; Edward McGrath to the position of assistant superintendent, Peoria State Hospital, Peoria, Ill.; David Miller to Cleveland City Hospital, Cleveland; James Neal to Freedman's Hospital, Washington, D. C.; Jack Owen to Indiana University Hospitals, Indianapolis; William Slabodnick to the position of assistant administrator, Massillon Hospital, Massillon, Ohio; Lacy Williams to North Carolina Baptist Hospital, Winston-Salem, N. C.; Gordon Williams to Ohio State University Hospitals, Columbus, Ohio.

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Army School Graduates 52 in Hospital Administration

FORT SAM HOUSTON, TEX.—Students who have completed the course of instruction at Baylor-Army Program in Hospital Administration, Army Medical Service School, Brooke Army Medical Center, have been assigned to administrative residencies as follows:

Lt. Col. Lawrence S. Albrecht to U. S. Army Hospital, Army Forces Far East; Capt. Richard G. Allen to 4466th U. S. Air Force Dispensary, Seymore Johnson Air Base, N. C.; Capt. Ben A. Ansley to 4237th U. S. Air Force Hospital, Turner Air Force Base, Ga.; Lt. Col. Reuben A. Baer to 7280th U. S. Air Force Hospital, Nouasser, French Morocco; Lt. Col. Stephen J. Beaudry to Office of the Surgeon General, Department of the Army, Washington, D. C.; Lt. Col. Shen-Hung Bien to Military Hospital, Formosa; Capt. Stanley E. Butler to 1170th U.S. Army Hospital, Fort Devens, Mass.

Capt. Daniel P. Cahill to 4018th U.S. Air Force Dispensary, Portsmouth, N.H.; Maj. Francis O. Chapelle to U.S. Army Hospital, West Point, N.Y.; Lt. Col. Ernest E. Cochran to medical section, 1st Army Headquarters, New York; Lt. Col. Martin S. Comella to Madigan Army Hospital, Tacoma, Wash.; Capt. James H. Couch to medical section, 1st Army Headquarters, New York; Lt. Col. William T. Covey to U. S. Army Hospital, Army Forces Far East; Maj. Melvin F. Cunningham to U. S. Army Hospital, Alaska; Capt. Willis R. Dawson Jr. to 7510th U. S. Air Force Hospital, Wimpole Park, England; Lt. Col. Herbert D. Edger to U. S. Army Hospital, Wolters Air Force Base, Tex.; Lt. Col. Ali Riza Erkan to Military hospital, Turkey; Maj. Robert D. Fakes to Walter Reed Army Medical Center, Washington, D. C.; Maj. Pedro G. L. Galang to Military hospital, Philippine Islands.

Lt. Col. Francisco E. Gandullia to Military Hospital, Peru; Col. William A. Hamrick to Army Medical Service School, Brooke Army Medical Center, Fort Sam Houston, Tex.; Lt. Col. Donald L. Hitchings to U. S. Army Hospital, United States Army, Europe; Maj. Margaret A. Hollinger to U. S. Army Hospital, Fort Belvoir, Va.; Maj. Laray D. Hooker to Walter Reed Army Medical Center, Washington, D. C.; Capt. Thomas H. Hoover to Madigan Army Hospital, Tacoma, Wash.; Maj. George B. Hughes Jr. to Valley Forge Army Hospital, Phoenixville, Pa.; Maj. Mary C. Jordan to U. S. Army Hospital, Korea; Maj. Eugene W. La Rocca to 334d U. S. Air Force Hospital, Otis Air Force Base, Mass.

Maj. Rupert S. Lewis to 7414th U.S. Air Force Hospital, Bordeaux, France; Maj. Leon E. Loll to Fort Knox Hospital, Fort Knox, Ky.; Lt. Col. Rifat M. Mahmood to Military Hospital, Pakistan; Maj. Burton W. Montgomery to U. S. Army Hospital, Camp Hanford, Wash.; Capt. D. K. Mylrea to Military hospital, Canada; Capt. Joseph P. O'Brien to 1607th U. S. Air Force Hospital, Dover, Del.; Lt. Col. George T. O'Reilly to Valley Forge Army Hospital, Phoenixville, Pa.; Capt. Jane C. Pesci to U. S. Army Hospital, Fort Polk, La.; Lt. Col. Thomas Pugh to U. S. Army Hospital, Fort Monmouth, N. J.; Capt. Joseph J. Quenk to 4034th United Air Force Hospital, Loring Air Force Base, Maine; Maj. Francis M. Raikowski to 2792d U. S. Air Force Hospital, Tinker Air Force Base, Okla.

Maj. Joseph R. Rodwell to 7422d U. S. Air Force Hospital, Laon, France; Capt. Lester S. Ross to 7428th U. S. Air Force Dispensary, Spangdahlem, Germany; Lt. Col. Gerard J. Sheehan to U. S. Army Hospital, Fort Dix, N. J.; Maj. Malcolm F. Slayter to 3902d U. S. Air Force Hospital, Offutt, Neb.; Maj. Fred W. Sweet Jr. to Brooke Army Hospital, Brooke Army Medical Center, Fort Sam Houston, Tex.; Capt. Robert A. Sweger to 4235th U. S. Air Force Dispensary, Little Rock, Ark.; Maj. Bob B. Thacker to 6038th U. S. Air Force Hospital, Misawa Air Base, Honshu, Japan.

Lt. Frederick T. Tompkins to Military Hospital, Canada; Maj. Helen Tremback to Brooke Army Hospital, Brooke Army Medical Center, Fort Sam Houston, Tex.; Lt. Col. John K. Wallace to U. S. Army Hospital, Germany; Lt. Col. Virgil T. Yates to U. S. Army Hospital, Fort Riley, Kan.; Capt. Donald E. Zboray to 2843th U. S. Air Force Hospital, Olmsted, Pa.

Yale University Announces Residencies

NEW HAVEN, CONN.—Students in hospital administration at Yale University have been appointed to administrative residencies as follows:

Janet Beach to Johns Hopkins Hospital, Baltimore; Francis Brecker to Springfield Hospital, Springfield, Mass.; William Clermont to Waterbury Hospital, Waterbury, Conn.; Lillian Jenkins to Elizabeth Steel Magee Hospital, Pittsburgh; Sheldon King to Mount Sinai Hospital, New York; Margaret Peters, Grasslands Hospital, Valhalla, N. Y.; Peter Pierdinock to Newton-Wellesley Hospital, Newton Lower Falls, Mass.; Jerome Sapolsky to Beth Israel Hospital, Boston; Paul Sternlof to New England Center Hospital, Boston; Francis Sullivan to Genesee Hospital, Rochester, N. Y.

University of Michigan Lists Residencies

ANN ARBOR, MICH.—Members of the class in hospital administration at the University of Michigan have been appointed to the following residencies:

John C. Bay to University Hospital, Ann Arbor, Mich.; Paul Carvisiglia to New England Center Hospital, Boston; Karl Dickerson to Indiana University Medical Center, Indianapolis; David Dimendberg to Mount Sinai Hospital, Cleveland; Dr. George Ellis to New York University-Bellevue Medical Center, University Hospital, New York; Darwin Finkbeiner to Little Traverse Hospital, Petoskey, Mich.; Symond R. Gottlieb to Blodgett Memorial Hospital, Grand Rapids, Mich.; Charles Gustafson to Good Samaritan Hospital, Portland, Ore.; Wayne Herhold to Henry Ford Hospital, Detroit.

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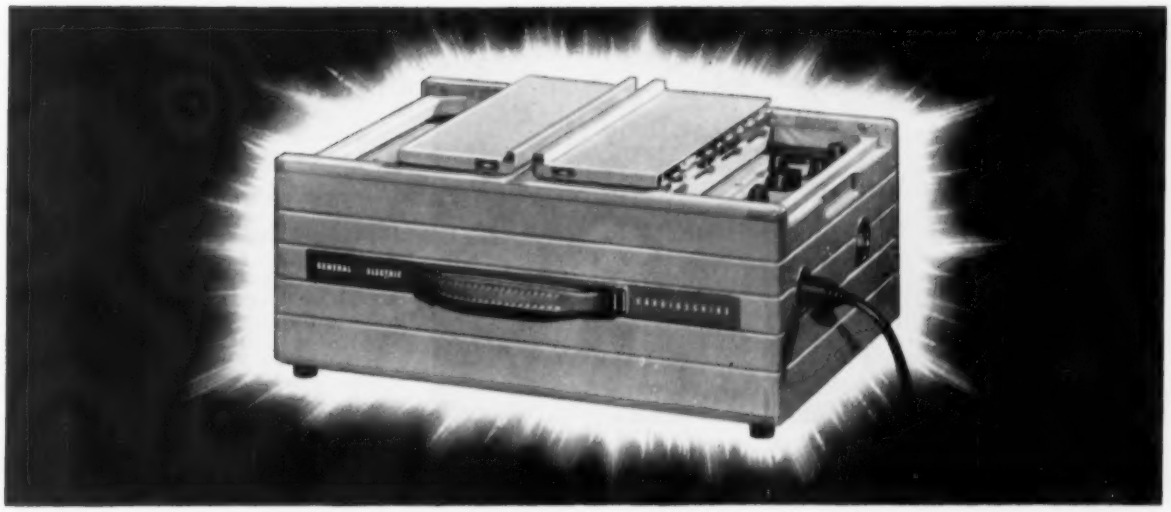

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UNIVERSITY OF CHICAGO

Students who have completed the academic portion of their work in the graduate program in hospital administration at the University of Chicago: Front row (left to right): John Deans, William Slabodnick, Jack Owen. Second row: Edward McGrath, Gordon Williams, Harold Autrey, Lacy Williams. Third row: James Neal, Richard Malone, John Griffith, David Miller, Gordon Beaty. Fourth row: So Zimmermann (coordinator), Vernon Forsman (associate director), Ray E. Brown (director), Richard Wittrup (associate director).

NORTHWESTERN UNIVERSITY

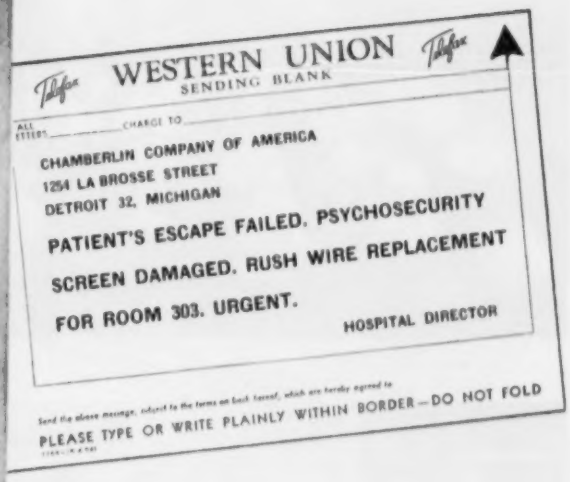
Administrative residents at Northwestern University: Front row: Jaime A. Proaño, Victor M. Sledge, Douglas R. Eitel, Dov Wolotsky, Rodrigo A. Moreno. Second row: Marvin Rappaport, James D. Anderson, Richard C. Stainback, Jerry L. Durr, Laura Jackson (associate director), Dr. C. U. Letourneau (director), S. J. Ruskjer, (preceptor), Maurice B. Shaw, Gordon S. Boughton, Peter J. Buttaro, Adam Coutts. Third row: Willard J. Leuthard, Thomas L. Byram, Theodore H. Johnson, Billy R. Talbert, William Van Slyke, George Skomsky, Charles M. Cooper, Gladys Post, Marie Oling, Mary Finger, David M. Smith, Joe S. Greathouse Jr., Neil S. Cooper, Joseph I. Hutchinson, Joseph W. Davis, Roland Wilpitz. Last row: Richard O. Thal, Harold V. King, Hansel B. O'Quinn, Elmer L. Harvey, Donald E. Hansen, John A. Erlman, Paul R. Donnelly, Maurice P. Coffee, Lawrence C. Davis, Warren J. Lenz, John P. Devins.

UNIVERSITY OF MICHIGAN

Members of the class in hospital administration at the University of Michigan: Front row (left to right): Charles Gustafson, Paul Carvisiglia, Symond R. Gottlieb, Karl Dickerson, John C. Bay, Robert Biz. Back row: Edward J. Connors (instructor), Darwin Finkbeiner, Dr. George Ellis, Wayne Herhold, David Dimendberg, Walter J. McNerney (director).

GEORGIA STATE COLLEGE OF BUSINESS ADMINISTRATION

Students in hospital administration at the Georgia State College of Business Administration: Seated (left to right): James W. Wilson, Maj. E. W. Smith, Ferrell B. Driskell, James R. Griffith, J. Lewis Ridgeway, Jewell E. May, William A. Barrett, Clovis S. Dailey, Shirley L. Owens, Tigner S. Zorn, Raymond E. Watson. Standing are: Dr. A. L. Jugo, Dr. S. R. Panggat, Dr. A. C. del Corro, Albert A. Webster, Robert H. Jones, Robert C. Couch, Paul D. Vogen, James K. Jarvis, Charles A. Ebbert, Rene G. Aliaga, Dr. R. C. Guiterrez, Dr. A. M. Cabrera.



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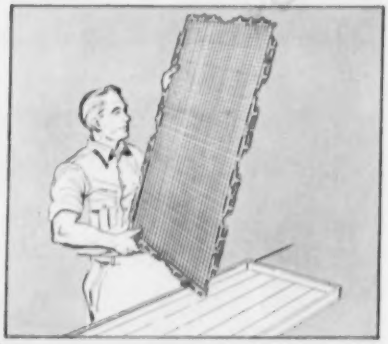
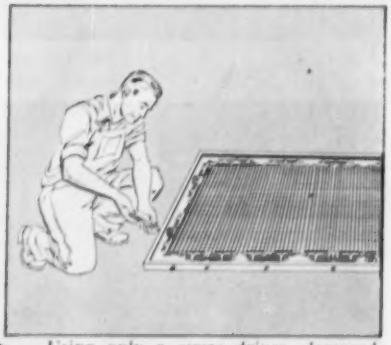


2 Replacement screen panel with all hardware applied in proper position is shipped by express.

3 When replacement arrives a hospital maintenance man simply removes hinge pins and lays swing section of unit on the floor.



4 Using only a screw driver, damaged screen panel is removed and replaced with a new panel, complete with factory-applied springs and clevises.

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ST. LOUIS UNIVERSITY

Members of the graduating class in hospital administration at St. Louis University: First row (left to right): Sister Daniel Marie, C.S.J.; Sister Marie Finbarr, O.S.F.; Sister M. Scholastica, R.S.M.; Sister Mary Margareta, D.D.R.; Sister M. de Paul, C.S.J.; Sister M. Calasantia, C.S.S.F. Second row: Sister Grace Marie, S.C.; Sister Marybelle, O.S.B.; Sister Emilene, S.S.J.; Sister Madeleine Sophie, M.S.C.; Sister Gertrude, F.C.S.P.; Sister Mary Salvatore, C.C.V.I. Third row: Sister Mary Eymard, C.C.V.I.; Sister M. Theophane, C.S.F.N.; Sister M. Consolata, C.D.P.; Sister Susanna, C.S.J.; Sister M. Patricia Aidan, C.S.J.; Sister Mary Beatrice, C.S.J. Fourth row: Sister Helen, D.C.; Sister Josephine, D.C.; Sister Anne William, D.C.; Sister Mary James, D.C.; Sister M. Cyprian, C.S.J. Back row: Charles E. Berry (associate director), Robert Biermann, David DeBacker, Edward J. Fitzgerald, Richard D. O'Hallaron, Thomas J. Underriner.

YALE UNIVERSITY

Members of the hospital administration class of 1957, Yale University: Front row: Margaret Peters, Janet Beach, Dr. A. W. Snoke (director, Grace-New Haven Hospital), George S. Buis (director, program in hospital administration), Lillian Jenkins. Back row: Peter Pierdinock, Francis Sullivan, Francis Brecker, Sheldon King, Jerome Sapolsky, Paul Sternlof, William Clermont, Bruce Burley.

UNIVERSITY OF MINNESOTA

Students in hospital administration at the University of Minnesota: Top row (left to right): William H. Maloy, Donald F. Andrews, Herbert L. Fromm, Mark H. Tibbetts, Robert L. Jepsen Edward R. Lynn, Peter S. Haviland, Elbert E. Gilbertson Jr., Andrew A. Hain. Center row: Roger G. Dvorak, John R. Jefferies, Robert G. Michaels, Bruce E. Fischer, Robert J. Fitzsimmons, Lloyd E. Detwiller, George H. Cowen Jr., Clarence W. Palmateer, J. Richard Arnzen, Donald F. Zuercher, Harold V. Weed, Frederick R. Wolf, Paul C. Balcom. Bottom row: R. Bruce Butters (instructor), Arthur G. Hennings (assistant professor), James A. Hamilton (director), Dr. Gaylord W. Anderson (director of school of public health), James W. Stephan (associate director), Edith M. Lentz, (assistant professor), Gerard W. Frawley, Alan M. Gilbert.

UNIVERSITY OF TORONTO

Members of the course in hospital administration at the University of Toronto: Back row: Clarence R. Horton, Dr. G. Dudley Barnett, Vernon E. Dressler, Moshe Katz, George A. Miller. Middle row: William B. Beatty, W. Ben Stefaniuk, Dr. Victor H. Radoux, Hugh R. McGann. Front row: Harold G. Dillon, (research fellow), Eugenie M. Stuart (associate professor), Dr. G. Harvey Agnew (director and professor), Dr. W. Douglas Piercey (assistant professor).

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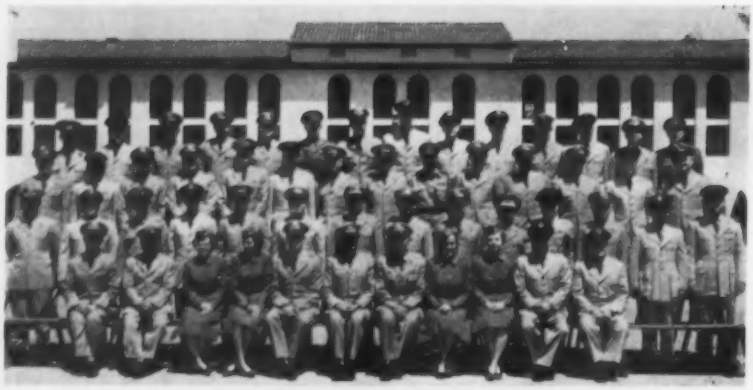

Degree candidates in hospital administration at the Army Medical Service School, Brooke Army Medical Center, Fort Sam Houston, Tex.: Back row (left to right): Lt. Col. Ali Riza Erkan, Capt. Daniel P. Cahill, Capt. James H. Couch, Lt. Col. Ernest E. Cochran Jr., Lt. Col. William T. Covey, Capt. Frederick T. Tomkins, Lt. Col. John K. Wallace II, Capt. Robert A. Sweger, Maj. Rupert S. Lewis, Capt. Joseph P. O'Brien, Maj. Burton W. Montgomery, Maj. Bob B. Thacker, Lt. Col. Stephen J. Beaudry, Capt. D. K. Mylrea. Third row: Col. William A. Hamrick, Capt. Willis R. Dawson Jr., Maj. Leon E. Loll, Maj. Robert D. Fakes, Lt. Col. George T. O'Reilly, Maj. Malcolm F. Slayter, Lt. Col. Thomas Pugh, Maj. George B. Hughes Jr., Lt. Col. Rifat M. Mahmood, Capt. Thomas H. Hoover, Maj. Melvin F. Cunningham, Maj. Francis O. Chapelle, Capt. Donald E. Zboray, Maj. LeRay D. Hooker. Second row: Lt. Col. Lawrence S. Albrecht, Lt. Col. Reuben A. Baer, Lt. Col. Shen-Hung Bien, Maj. Joseph R. Rodwell, Capt. Stanley E. Butler, Lt. Col. Gerard J. Sheehan, Maj. Pedro G. L. Galang, Lt. Col. Samuel L. Andelman, Maj. Fred W. Sweet Jr., Lt. Col. Francisco E. Gandullia, Capt. Richard G. Allen, Lt. Col. Virgil T. Yates, Maj. Francis M. Raikowski, Maj. Eugene W. La Rocca. Front row: Lt. Col. Herbert D. Edger, Lt. Col. Martin S. Comella, Maj. Mary C. Jordan, Maj. Margaret A. Hollinger, Lt. Col. Sam A. Edwards (instructor), Brig. Gen. Elbert DeCoursey (school commandant), Col. Frederick H. Gibbs (director, department of administration), Capt. Jane C. Pesci, Maj. Helen Tramback, Capt. Lester S. Ross, Capt. Joseph J. Quenk.

Toronto Announces Residency Appointments

TORONTO, ONT.—Resident appointments for the class in hospital administration at the University of Toronto have been announced as follows:

Dr. G. Dudley Barnett to Toronto Hospital, Weston, Ont., and Saskatchewan Hospital, Saskatoon, Sask.; William B. Beatty to Kingston General Hospital, Kingston, Ont.; Vernon E. Dressler to Norton Memorial Infirmary, Louisville, Ky.; Clarence R. Horton to Jackson Memorial Hospital, Miami, Fla.; Moshe Katz to Montefiore Hospital, New York; George A. Miller to Monmouth Memorial Hospital, Long Branch, N. J.; Dr. Victor H. Radoux to Sunnybrook Veterans' Hospital, Toronto, Ont.; W. Ben Stefaniuk to Toronto East General Hospital, Toronto, Ont.

Patients' Point of View Highlights Meeting of Upper Midwest Conference

(*Continued From Page 56*)

ing. Anybody who scares us arouses feelings of irritability and resentment, she pointed out. "There are some patients who are constantly heckling," Dr. Johnson pointed out, "and they have to be told to simmer down and behave themselves. But let's say it without hostility."

Analyzing specific conditions that are likely to arouse the patients' fears, and hence their anger, Dr. Johnson listed amputations, which make patients feel as if they have lost a member of the family; eye operations, with the terrible feeling of isolation they engender; orthopedic conditions that require a full body cast in which many patients feel quite disoriented; operations around the throat and neck, which arouse fears of suffocation, and, finally, polio. "Just imagine how *you'd* feel being paralyzed and put into a respirator with that tight rubber collar around your neck—and not able to get out of it," she urged.

Dr. Johnson pointed out that patients who have had a "rough" life are the ones who have greatest difficulty in adjusting to hospital care. They feel a particular need to take care of themselves and never let their guard down, she explained, a statement that was vigorously supported by a later speaker.

The first of the trio of patients to address the audience was Lucius Gale, who had been unable to speak for eight years following a laryngectomy. Having more or less accidently discovered the technic of esophageal speech seven years ago, he has since made it his hobby to visit laryngectomy patients in hospitals to prepare them for a life without a voice—"so they won't have to go through the same thing that I did." Mr. Gale conducts speech classes and has organized a club for laryngectomy patients and he feels strongly that nurses must be trained to work with the patients and prepare them for the return to everyday living. For example, he stated, not all nurses remember to teach patients how to sterilize the tracheotomy tube and the knowledge of how to do it is very important to them.

Mr. Gale's earnest kindliness, his laborious speech, and the painful pauses while he struggled to get the words out were probably more effective than his actual words in arousing sympathy. Just the effort of listening to him helped the audience to comprehend a bit of what he had suffered and to suffer with him.

The serious mood was lightened by Mrs. Ruth Head, a maternity patient who, by and large, had had a wonderful time in the hospital and said so with enthusiasm. The excellent prenatal classes sponsored by the Twin Cities Hospital Council have made friends for all hospitals, Mrs. Head asserted. Her own feeling was one of intense gratitude at the information given and the opportunity to tour a hospital, which went far to relieve her apprehensions.

Mrs. Head offered only one serious complaint about her hospital stay. It grieved her to end her otherwise happy talk on a sour note—but that's the way her hospitalization ended.

"It took me an awful lot longer to get out of that hospital than it did to get into it," she reported. "My husband was gone so long I couldn't think what was happening to him. All it was: He was trying to get an itemized bill to give the insurance company and the cashier wouldn't give it to him. They wanted cash right there and he wanted the itemized bill! Well, we finally got

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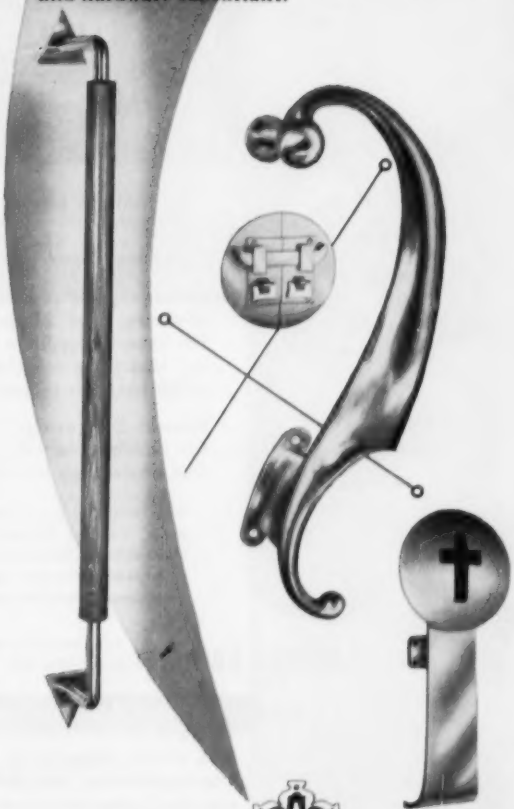

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out of there and my husband asked them to send the itemized bill next week. But when it came it wasn't itemized so he had to go to the hospital and start all over again."

Mr. Head finally got his itemized bill so the insurance company would pay him so he could pay the hospital, but Mrs. Head is still baffled by the reluctance of hospital officials to itemize their statements. It seems such a simple thing to her.

It remained for the third patient—massive and immobile in the wheel chair in which he will probably spend the rest of his life—to bring home to the administrators just what Dr. Johnson meant when she talked about patients' fears and resentments. Fred Vant Hull, former professional football player turned television broadcaster, started off diffidently. He explained that he hadn't prepared a speech; he just wanted to tell them about some of his experiences as a polio patient. So he told them:

About being half-carried, half-dragged into the hospital by his wife and propped on a chair while she went through the lengthy admitting formalities. Before they were over he had fallen out of the chair and lay on the floor.

About the telephone call to Mrs. Vant Hull (who had been sent home while the tests were being made) advising her that her husband had polio and had to be transferred to University Hospital and instructing her to rush down to the hospital with $10 to pay the ambulance fee.

About the head nurse who bawled him out for screaming and pushing the call bell for help when he felt the paralysis progressing.

About the nurse — the same one probably — who informed him indignantly that "those glass drinking tubes cost the hospital 15 cents each" when one slipped out of his weakening left hand.

About the nurse who snapped: "Why dontcha mimeograph it?" when he gave her anxious instructions about propping up his arms and legs when she opened the respirator to administer routine care.

About the people who removed the tracheotomy tube with a jerk instead of slipping it out.

About the nurses who wouldn't answer any of his questions because "it isn't etiquette to talk to patients."

Conceding that he had probably been a very difficult patient, the speaker pointed out that under similar circumstances any patient is going to be difficult. "You're going to scream and you're going to push that button," he assured his audience.

"The hate just wells up inside you. Actually you're hating yourself but I wonder sometimes if some of that hate doesn't spread to the doctors and nurses. I'm not condemning nurses," he added. "I love them. I know a lot of us owe our lives to them. But they ought to perform even perfunctory duties with care and respect. When they open up that iron lung they ought to listen to what that guy is telling them. He's scared. There's a tremendous difference in how you handle people—and in the people you handle."

The conclusion of Mr. Vant Hull's talk brought a roar of applause remarkable from usually blasé hospital audiences. This one speaker, at least, had succeeded in getting the patient's point of view across.

Dr. Edith Lentz of the University of Minnesota course in hospital administration picked up where Mr. Vant Hull left off to drive home the theme of treating patients with respect. She impressed upon the delegates that it is

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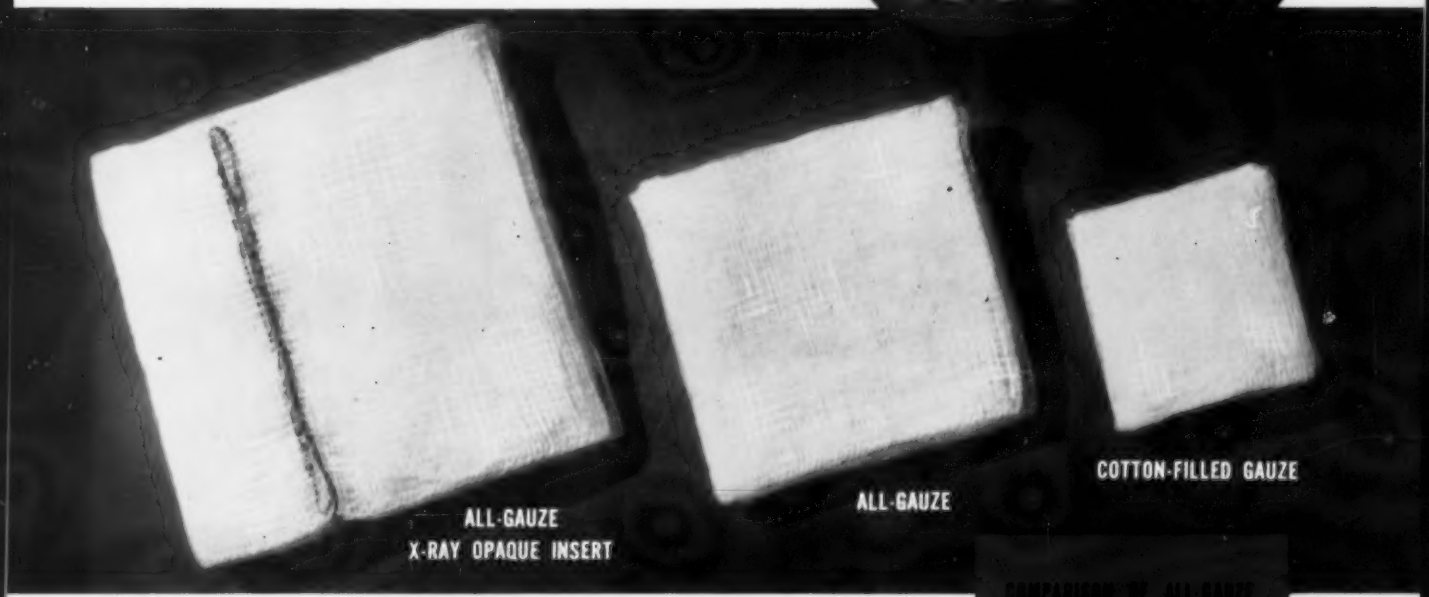

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All edges are carefully, neatly folded inside; no loose threads can escape. Carolina sponges are uniform and dependable.

Monofilament X-ray opaque string makes good clear pattern on plates from any angle. Meets hospital standards for safety, ease of use.

For greater economy outside the operating room, substitute Carolina cotton-filled sponges for all-gauze. The thin even layer of combed cotton is very absorbent. Convenient for pressure dressings as well as post-operative dressings and general wound care.

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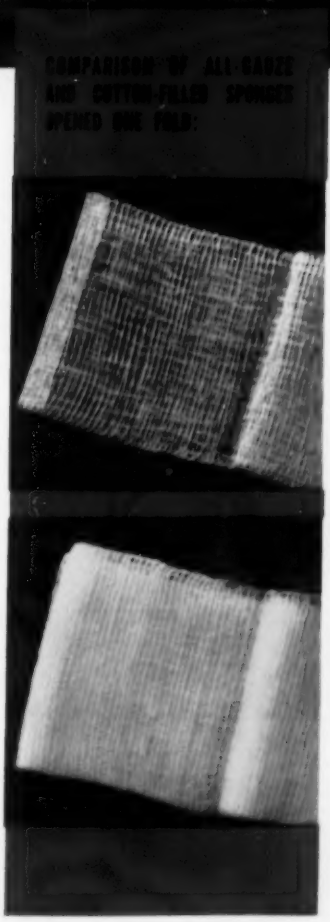

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completely free of nibs and wispy ends.
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find that they save time and money.
Cleaning instruments and equipment,
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super	2000 per case
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large	2000
medium	4000
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special is same size as large but is almost twice as dense

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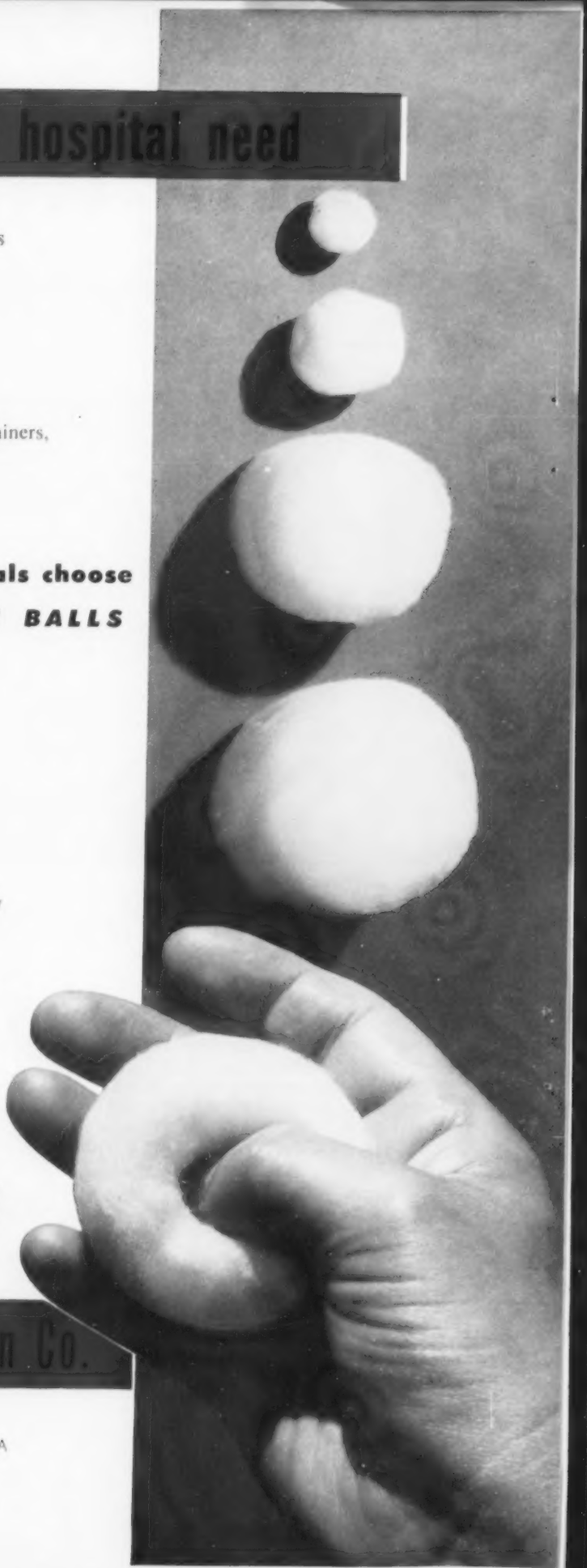

Carolina Absorbent Cotton Co.

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CHARLOTTE 1, NORTH CAROLINA

the administrator's job to ensure the proper treatment of patients by creating the environment in which patients and employes alike can feel secure.

"All of us, whether we are patients, prospective patients, or people who work in hospitals, need to feel part of a creative community where reverence for life is held to be a cardinal virtue. Within the hospital it is the administrator's function to keep this perspective clear," Dr. Lentz asserted.

Whether because the excitement of the Thursday morning session was too much for them, or the delegates were just too tired from their social activities to struggle out to the meeting, the audience was noticeably depleted by Friday morning. As it turned out, those who stayed away missed another bit of drama. Dr. James Rogers Fox, Minneapolis internist and public relations director of the Minnesota State Medical Society, demonstrated both of his skills in the course of his talk on "Why the Practice of Medicine Is Changing." When a member of the audience collapsed suddenly, Chairman Donald W. Cordes came to the platform to request assistance from "another doctor." No other doctor responded to the call so Dr. Fox descended from the platform, ministered to the patient, and returned some 30 minutes later to finish his speech, entirely unruffled by the interruption.

During Dr. Fox's unscheduled absence, Dr. Albert W. Snoke, A.H.A. president-elect, took over and delivered a spirited challenge to those members of the medical profession who believe that only the doctor is concerned with the care of patients. The administrator's rôle in this area is becoming more and more important, Dr. Snoke asserted, and his rôle will some day equal that of the physician—in different ways.

Whether the administrator is a doctor or a layman is quite immaterial, Dr. Snoke believes. "I'm not a doctor in my administrative activities; I'm a public health man and so are my lay assistants."

If the administrator is treated as a partner by the doctor, Dr. Snoke said, the pattern of how they can work together becomes clear: through the medical staff committee and the joint conference committee with the governing board. The administrator should sit on both of these committees, Dr. Snoke contended, not as "secretary" or guest but as an equal partner. "There is not one question out of a hundred that comes up at medical staff meetings that isn't important to the administrator," he stated.

At the close of the meeting the Hospital Industries Association award to the best exhibitor was presented to the Eli Lilly Company, Indianapolis, with Hill-Rom Company, Batesville, Ind., and Remington Rand, Inc., New York, receiving honorable mention.

NEW OFFICERS

Sister Rose Marie, administrator of St. Mary Hospital, Pierre, S.D., moved into the presidency of the Upper Midwest Hospital Conference as Byron Jackson, administrator, St. Luke's Hospital, Fargo, N.D., finished his term of office. Donald W. Cordes, administrator, Iowa Methodist Hospital, Des Moines, was named president-elect.

Newly elected to the board of trustees is Dr. Ezra Bridge, head of Mineral Springs Sanatorium, Cannon Falls, Minn. Other board members are: Louis B. Blair, St. Luke's Methodist Hospital, Cedar Rapids, Iowa; Robert W. Goodman, Associated Hospital of Manitoba, Winnipeg, Manit.; Harold C. Mickey, Rochester Methodist Hospital,

Rochester, Minn.; J. M. McIntyre, Winnipeg, Manit.

Also on the board are: Sister Mary Bede, Columbus Hospital, Great Falls, Mont.; Richard Lubben, Bozeman Deaconness Hospital, Bozeman, Mont.; Byron Jackson; Sister Paul McCarthy, St. Alexius Hospital, Bismarck, N.D.; Jack L. Rogers, Sioux Valley Hospital, Sioux Falls, S. D.

Final sessions of the Upper Midwest conference showed an attendance of 4580 persons.

"Holy Discontent" Is Key to Progress, Cardinal Tells Catholic Delegates

(*Continued From Page 67*)

hospital, plug it into a 110 volt circuit and start making isotopes. It almost runs itself automatically, and can make useful quantities of over 100 isotopes.

"This low cost reactor doesn't make tremendous quantities, but radioisotopes are generally only used in very small quantities. The radioisotopes in which we are most interested are those that have a very short half-life, so that they do not remain in the body to do biological damage. Also, hospitals could become badly contaminated if very intensely active isotopes that remain radioactive for a long time were used. With the small, low-powered reactors, very small quantities are used and you get rid of them very rapidly."

Despite the substantial volume of hospital construction in the postwar years, there is still a shortage of 850,000 hospital beds, according to the Hill-Burton state plans, Dr. John W. Cronin, chief of the Division of Hospital and Medical Facilities, U. S. Public Health Service, reported to the convention.

Since the Hill-Burton program started nine years ago, 2800 projects have been approved, adding 128,000 beds, Dr. Cronin said. More than half the approved projects were voluntary nonprofit hospitals, he added. More than 2000 projects have been completed; 600 communities now have hospitals where none existed prior to 1946, and 20 per cent of all Hill-Burton funds have gone into teaching hospitals.

Nevertheless, Dr. Cronin pointed out, the bed deficit still exists, and, "we must remember that reference to beds and bed need is only symbolic of services and service deficits in identified areas of patient care.

"Our annual population increase and the obsolescent state of our health facilities complicate and impede our progress. It is not pleasing to realize that 50 per cent of the hospitals in the nation are over 50 years of age, when the average life expectancy of a hospital is 50 years. The functional obsolescence of many of the older hospitals present an even more perplexing problem in relation to modern medical practices."

Especially, Dr. Cronin said, deficiencies exist in areas relating to mental health, chronic illness, nutritional diseases and rehabilitation. "It is through continued programs of education in all these areas that many of the deficiencies will be eliminated," he said.

Weak spots in the nation's health insurance and prepayment plans were pointed out by Joseph A. Beirne, president of the Communication Workers Union, who addressed the convention on the relationship between organized labor and voluntary hospitals.

Health provisions for workers have been improved by labor-management negotiations in recent years, Mr. Beirne said. But basic weaknesses remain, he added. Among them, he named:

1. Employes and their families are covered only during the period of employment. No provisions are made for a period of unemployment, and, frequently, coverage is limited to the employe's place of residence.

2. Emphasis is placed on "protection," or service in time of illness and plans do not encourage periodic physical check-ups, early diagnosis and preventive measures.

3. In many cases coverage is only partial in terms of "the real costs of medical care and hospitalization." This limitation is especially true in case of long-term or catastrophic illness.

4. Most plans are based on the indemnity principle, "which fragments man and places a price tag on his various organs and limbs."

Organized labor is deeply interested in the health of workers and, in fact, the entire nation, Mr. Beirne assured the convention. "We will cooperate with the medical profession, the insurance field and industry in bringing about a better, and much needed, general health program," he declared. "The success of a private health program depends on the ability of the medical profession and the insurance field to develop a general, nonprofit

TOASTMASTER HOT-FOOD SERVERS ASSURE PIPING-HOT OVEN-FRESH MEALS!

At the Charleroi-Monessen (Charleroi, Pa.) Hospital complete meals are kept hot in mobile Toastmaster Hot-Food Servers while being transported to patients!

One of 6 Toastmaster Hot-Food Servers on its way to floors. Compact size and sturdy rubber casters make it easy for even the smallest woman to push. All electric kitchen also includes 4 Toastmaster Toasters which provide delicious, golden-brown toast daily.

Patients long remember the fast service and hot, appetizing food served at *this* modern hospital! As shown above, plates of hot food are assembled in the main kitchen, then placed in the reliable Toastmaster Hot-Food Servers. Each Hot-Food Server is then wheeled to the elevator and taken to its assigned floor where it is met by the cold food and tray carts. The completely assembled trays are then delivered to the patients. Meals arrive nourishing, hot, and oven-fresh in *both* taste *and* appearance!

Unique 6-sided air circulation, individual drawer moisture control and accurate thermostatic heat control maintain hot foods at the peak of perfection for hours, if necessary. The gleaming, stainless steel drawers and exterior provide the ultimate in food sanitation.

Ask your food service equipment dealer for more information about this hard-working plug-in appliance. Plan now to speed service, cut food costs, and maintain higher food quality with "Toastmaster"* Hot-Food Servers!

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4-drawer Mobile
$540.00†
holds 32 plates of hot food

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New **TOASTMASTER Hot-Food Server**

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†Prices slightly higher in Pacific Coast states.

and voluntary plan—like Blue Cross—that will stay within the financial reach of our people. They must also support governmental assistance for our aged, chronically ill, unemployed and indigent.

"While we want privately operated systems to work, we are not unmindful of those who desire to profit on the ill health of America. Such profit can keep America very sick. Our answer to a continuation of such actions is national health insurance."

Noting that hospitals are frequently misunderstood and misinterpreted, Mr. Beirne said the lack of good hospital public relations is due to a "general lack of active participation of citizens in their community hospitals."

To establish better citizen participation and public relations for community hospitals, Mr. Beirne recommended:

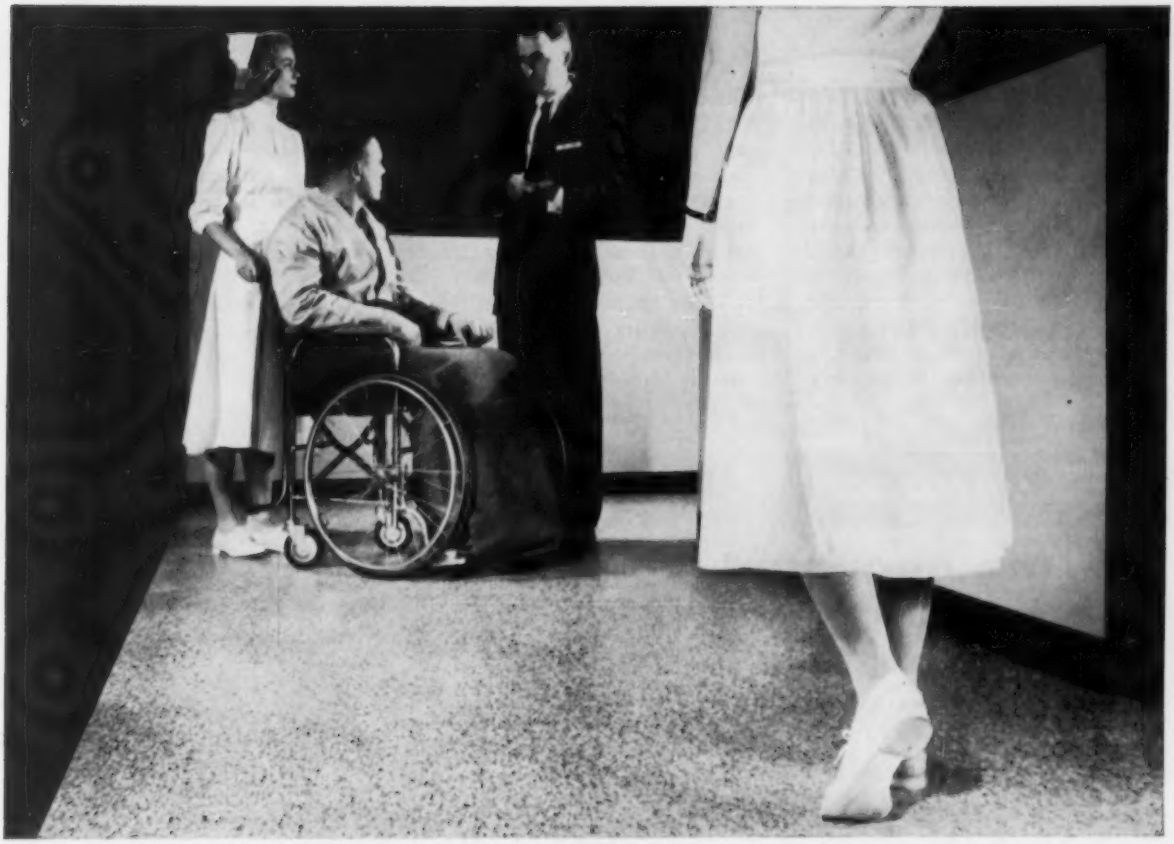
1. Adequate consumer representation, including labor, on hospital boards and committees.
2. Consumer or patient advisory committees to administration.
3. Institutes in human relations for the entire staff, including physicians.
4. Organized "come-see" tours of hospital facilities by people of the community.
5. Educational programs in hospital care, objectives, philosophy, operating procedures and budgets in the community at large.

"Our hospitals have a good story to tell," Mr. Beirne concluded, "a story that will help deepen the public's understanding of this vital community service."

Hospitals participating in adoptions managed by unauthorized adoption agencies are often cooperating in illegal and immoral actions, Rev. Joseph Springob, diocesan director of Catholic Charities, Milwaukee, warned administrators attending the convention. "By indulging in such actions they are helping to undermine a system designed to safeguard the religious rights of Catholic children," he added. "People who place children 'on their own' should conform to the law, but they frequently do not; furthermore, little can be done to assure that a child placed by his mother, or by a physician, lawyer, hospital or other person will go into a home of his own religion."

There is only one method of safeguarding the rights and needs of natural parents, the adopted child, and adoptive parents, Father Springob said: to have the whole adoptive process controlled and operated by a standard social agency equipped and experienced in adoptive placement.

"Only such an agency has policies, practices and resources for accomplishing the purposes of adoption," he concluded. "Only such an agency has formulated policies based on its own experience and that of similar agencies; only such an agency has caseworkers trained to practice the art and science of selecting adoptive parents, placing and supervising children, and guiding adoptive parents in the unique experience of loving, caring for and shaping the potentialities of children whom they did not conceive; only such an agency has resources for medical, psychological and legal consultation; only such an agency can stand ready to reaccept a child if, during the time of trial and adjustment prior to legal adoption, it becomes evident that the child or the adoptive parents are going to be damaged by the adoption; only such an agency can keep and have available when needed a comprehensive record of the whole transaction from a time prior to the child's birth until his legal adoption, and, usually,



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This new, exclusive flooring resists wear— keeps its pattern as no other 1/8" linoleum can!

Abrasive Wheel Test proves *Sequin* will "look like new" through long service life!

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Here is an ideal floor covering for hospital corridors and rooms—and other heavy traffic areas! Gold Seal "Sequin" wears and wears. It gives a sanitary, virtually seamless expanse of wall-to-wall floor. The satin-smooth surface seals out dirt and resists stains...it's so easy to keep clean and sparkling!

Gold Seal "Sequin" is highly resilient . . . quiet and comfortable underfoot. Seven patterns provide a wide selection to match any decorative plan. See the distinctive, new "Sequin," get full information at your Gold Seal Dealer's today!

SPECIFICATIONS:
6-ft. wide yard goods, 1/8" gauge burlap backed. Install over suspended wood or suspended concrete subfloors. Available in: grey, green, dark brown, white multi, grey mix, taupe, beige. Also made in standard gauge for residential use—in 18 colors.

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only such an agency can make sure that the natural parents will not seek to regain their child."

Financial remuneration is becoming important to many medical students in the selection of internships, Dr. John S. Hirschboeck, dean of the Marquette University School of Medicine, said in a talk on internship and residency programs. "The mercenary spirit of our times is disturbingly present in some of our medical students," Dr. Hirschboeck declared. "When a prospective intern is more interested in salary and bonuses than in the educational program, and if he is greatly concerned about working hours, I recommend that he not be employed, because such an intern is apt to demoralize the group and destroy a successful program."

Nevertheless, Dean Hirschboeck said, interns must be paid enough to take care of their personal living expenses. Married interns may be paid more through the provision of an allowance for living quarters, he added. However, "the salary should not be the inducement in attracting interns. It is generally conceded that the poor internships provide the higher compensations. Bonuses, gifts, side pay by the staff, overtime pay and other augmentations of salary are shortsighted and eventually lead to failure of the program.

"Once an internship wins a good reputation and quotas are filled, it is necessary to continue the efforts. At first, there is a temptation to enlarge the quota. This is usually a poor policy, because it means that many of the qualities of the good internship are diluted, and the entire program may collapse."

Hospitals that cannot meet present-day training standards for interns and residents should revert to the old practice of employing house physicians, Dr. Hirschboeck advised. "A higher salary is required, but at the same time more service can be expected," he said. "Two or three house physicians, each earning eight or nine thousand dollars a year, should be able to give the service of six or seven interns. If the hospital should subsequently establish an internship program, one or more of the house physicians can be eliminated. It may be desirable for the medical staff to contribute toward the salaries of the house physicians, because of the augmented medical service given their patients. Many physicians employ assistants, and there is no reason why a medical staff cannot pool its efforts to employ one or more hospital assistants."

Autopsies Declining in Quality, It Is Charged

CHICAGO. — Autopsies might better be performed by the physicians and surgeons who are personally interested in their cases, instead of by pathologists, Dr. Isaac Starr suggested here recently.

In an article in the *Journal of the American Medical Association*, Dr. Starr criticized today's autopsies as "routine work" and added that interest in the autopsy has declined in our time from the peak of 25 or more years ago, when American medical students commonly attended German and Viennese institutions to study pathology.

The keenness of personnel performing autopsies has declined, Dr. Starr asserted, and autopsies are not done as well as they once were. "What was once a privilege is now a burden," he said.

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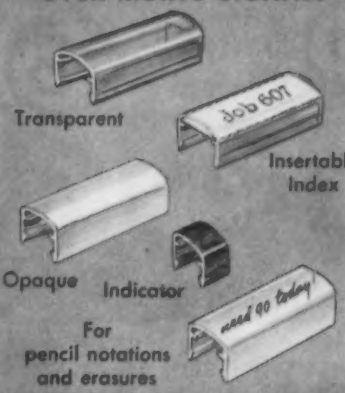

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Louisiana Association Elects Dr. MacKenzie

(*Continued From Page* 142)

to obtain the desired changes, all hospital administrators and trustees will have to work with their senators and legislators to explain the problem. Mr. Bankston announced his resignation effective as soon as his successor is named.

David Ferri, Eastern Airlines pilot, and adviser to his company on employe training programs, discussed public relations. He urged hospital administrators to make a careful survey of their own employes to see if they could discover some individual who has a talent for handling public relations programs. He also urged that hospitals institute well organized and conducted employe training programs as the basis for effective public relations procedures. "Every hospital employe must look on every patient as a potential psychopath looking for trouble and the hospital employe must know how to handle such cases," Mr. Ferri said.

Friday afternoon's session was devoted to an open forum discussion of trustee-administrator-medical staff relations moderated by Everett W. Jones of the Modern Hospital Publishing Company, Chicago. Dr. Gordon Peek, member of the attending staff of the Baton Rouge General and Our Lady of the Lake hospitals in Baton Rouge, discussed the responsibility of individual members of the medical staff. He urged hospital trustees to elect one or more medical staff members to membership on the governing board. "Hospital staff physicians are forced to waste too much time in attending too many meetings," he concluded.

New officers of the Louisiana Hospital Association are: Herman Herold, administrator of the North Louisiana Sanatorium in Shreveport, succeeding Raymond C. Wilson, administrator, Baptist Hospital, New Orleans, as president; president-elect, Dr. John MacKenzie, administrator, Touro Infirmary, New Orleans; vice president, Freeman E. May, administrator, Alexandria Baptist Hospital, New Orleans.

Massachusetts Association Elects Dr. Dean A. Clark

BOSTON.—Dr. Dean A. Clark, director of Massachusetts General Hospital, was chosen president-elect of the Massachusetts Hospital Association at its 20th annual meeting here last month. Dr. Clark will succeed Dan Traner, administrator of Lynn Hospital, Lynn, who was installed as president.

Left: W. Franklin Wood receives copy of resolution giving him life membership in Massachusetts association from Dr. Guy W. Brugler, retiring president.

Other officers elected were: treasurer, Georgie M. Boulter, administrator of New England Baptist Hospital, Boston; trustees: the Rt. Rev. A. C. Dalton, director, Catholic hospitals, archdiocese of Boston; Robert P. Simmons, director, St. Luke's Hospital, New Bedford, and Robert D. Lowry, executive director, New England Deaconess Hospital, Boston.

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Administrator of Hialeah Hospital, Hialeah, Florida.

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COMING EVENTS

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, 14th Annual Institute, Indiana University, Bloomington, July 15-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Meeting, Palmer House, Chicago, Sept. 15-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS INSTITUTES: 24th Chicago, University of Chicago, Sept. 4-14; 7th Chicago Advanced, University of Chicago, Sept. 10-14.

AMERICAN COLLEGE OF SURGEONS, CLINICAL CONGRESS, Fairmont Hotel, San Francisco, Oct. 8-12.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Palmer House, Chicago, Sept. 17-20; Midyear Conference for Presidents and Secretaries of State Hospital Associations, Palmer House, Chicago, Feb. 4, 5.

AMERICAN HOSPITAL ASSOCIATION INSTITUTES: Hospital Pharmacy, University of Chicago, Chicago, Aug. 20-24; Evening and Night Nursing Service, Adolphus Hotel, Dallas, Oct. 1-4; Medical Record Library Personnel, Hotel Jefferson, Richmond, Va., Oct. 15-19; Administrators' Secretaries, Edgewater Beach Hotel, Chicago, Oct. 22-26; Operating Problems for Small Hospitals, Vermont Hotel, Burlington, Vt., Oct. 25, 26; Hospital Auxiliary Leadership, Cleveland, Nov. 1, 2; Nursing Service Administration, Cincinnati, Nov. 5-9; Operating Problems for Small Hospitals, Winnipeg, Nov. 1, 2; Physical Therapy, San Francisco, Nov. 5-9; Dietary Department Administration, Denver, Nov. 12-16; Supervisory Training Workshop, Montreal, Nov. 26-30; Hospital Safety Seminar, Chicago, Nov. 26-30; Maintaining Standards of Patient Care in Hospital Systems, Hershey, Pa., Nov. 28-30.

ARIZONA HOSPITAL ASSOCIATION, Westward Ho Hotel, Phoenix, Nov. 15-17.

ASSOCIATED HOSPITALS OF ALBERTA, MacDonald Hotel, Edmonton, Oct. 16-18.

ASSOCIATED HOSPITALS OF MANITOBA, Royal Alexandria Hotel, Winnipeg, Oct. 29-Nov. 1.

CALIFORNIA HOSPITAL ASSOCIATION, San Jose, Oct. 24-26.

COLORADO HOSPITAL ASSOCIATION, Broadmoor Hotel, Colorado Springs, Nov. 6, 7.

CONNECTICUT HOSPITAL ASSOCIATION, South New England Telephone Company Auditorium, New Haven, Nov. 15.

FLORIDA CHAPTER OF THE AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Institute and Workshop, Daytona Plaza Hotel, Daytona Beach, Oct. 17-19.

FLORIDA HOSPITAL ASSOCIATION, Jacksonville, Fla., Nov. 29, 30.

INDIANA HOSPITAL ASSOCIATION, Student Union Building, University of Indiana Medical Center, Indianapolis, Oct. 24, 25.

INTERNATIONAL CONGRESS ON MEDICAL RECORDS, Shoreham Hotel, Washington, D.C., Oct. 1-5.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 15, 16.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Oct. 31-Nov. 2.

MINNESOTA HOSPITAL ASSOCIATION, Hotel St. Paul, St. Paul, Nov. 9.

MISSISSIPPI HOSPITAL ASSOCIATION, 25th annual convention, Hotel Edwards, Jackson, Oct. 18, 19.

MONTANA HOSPITAL ASSOCIATION, Florence Hotel, Missoula, Oct. 10-12.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Hotel Statler, Washington, D.C. Oct. 28-31.

NEBRASKA HOSPITAL ASSOCIATION, Hotel Fontenelle, Omaha, Oct. 25, 26.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 8, 9.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 22-24.

OREGON ASSOCIATION OF HOSPITALS, Hotel Senator, Salem, Oct. 8, 9.

SASKATCHEWAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Oct. 24-26.

VERMONT HOSPITAL ASSOCIATION, Long Trail Lodge, Pico Peak, Rutland, Oct. 17, 18.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 16, 17.

WASHINGTON HOSPITAL ASSOCIATION, Chinook Hotel, Yakima, Oct. 10, 11.

WEST VIRGINIA HOSPITAL ASSOCIATION, Hotel Chancellor, Parkersburg, Oct. 11-13.

1957

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 27-Mar. 1.

ASSOCIATION OF WESTERN HOSPITALS, Statler Hotel, Los Angeles, May 6-9.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 4, 5.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, N.J., May 16-18.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 22-24.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo., April 10-12.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, Mar. 25-27.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 29-May 2.

UPPER MIDWEST HOSPITAL CONFERENCE, Auditorium, Minneapolis, May 15-17.

Drop in Infant Blindness Reported in New York State

ALBANY, N.Y.—Infant blindness caused by retrolental fibroplasia has dropped 83 per cent in New York State in the last year, according to a report by Dr. Alfred Yankquer, director of the bureau of maternal and child health, State Department of Health, and his associates.

The dramatic drop came after hospitals adopted procedures limiting the oxygen concentrations given premature babies. A state requirement that all cases of blindness be reported to the state commission for the blind made it possible to observe the effects of the oxygen curtailment.

The health team said that high concentrations of oxygen administered to premature infants appear to affect blood vessels in the retina and to cause scarring. The retina shrinks as a result of scarring and is eventually destroyed.

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- Engineering Consultation Based on 77 Years of Reliability and Leadership In Window Development.
- Pre-engineering Collaboration in applying time-proven, basic designs to the specific project.
- Engineering Field and Sales Cooperation with all parties responsible for the project's completion.
- Engineered Detailing specifically for each project—individualized "custom planning."
- Engineering Controlled Follow-through on all manufacturing operations involved in completing a specific contract.
- Engineered Installation Preparation—detailed marking, scheduling and delivery in Bayley's own trucks to the job site.
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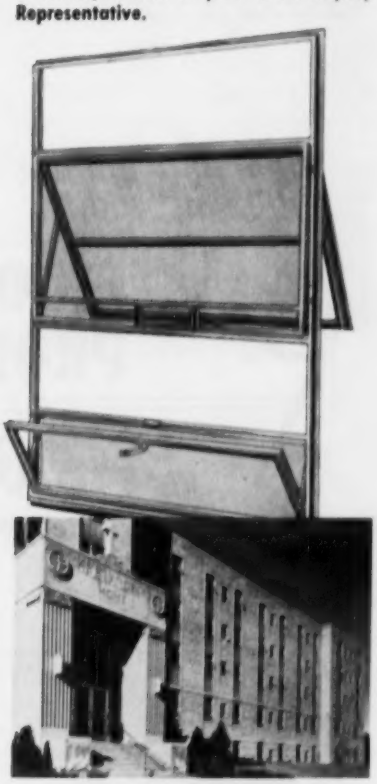
The over-all reliability of a 77 year old, nationally recognized, financially responsible company with complete, modern manufacturing facilities; supported by a nation-wide sales engineering and service organization.

Bayley Projected Windows (and Bayley Curtain-Walls and Window-Walls) — in aluminum and steel — have had a major influence on today's trend from the old conventional to the modern in hospitals, homes and institutions. If you are not familiar with Bayley Details see Sweet's or write; or call in your local Bayley Representative.



Bayley Projected Windows in the St. Andrew Home, Chicago suburb. Architect, Leo Strelka, Oak Park, Ill.; Builder, John Gebhardt & Son, Chicago, Ill.

QUALITY APPROVED P-A2

WE USE ALCOA ALUMINUM

THE WILLIAM BAYLEY CO.

Springfield, Ohio

District Sales Offices: Springfield • Chicago • New York • Washington

ABOUT PEOPLE

(*Continued From Page 88*)

H. L. Burgin has assumed the duties of administrator of Los Alamos Medical Center, Los Alamos, N.M. Prior to his appointment, Mr. Burgin was a member of the administrative staff at Barnes Hospital, St. Louis. Before going to Barnes, Mr. Burgin was administrator of Burge Hospital, Springfield, Mo. He has also been assistant director of the City Hospital System in Winston-Salem, N.C.; administrator of Harnett County Hospital, Dunn, N.C., and assistant superintendent of Roper Hospital, Charleston, S.C. Mr. Burgin is a graduate of Northwestern University's course in hospital administration, a member of the American College of Hospital Administrators, and past president of the Missouri Hospital Association.

Robert Cole has been named administrator of Bound Brook Hospital, Bound Brook, N.J. Mr. Cole has served as administrator of the U.S. Government Hospital in the Panama Canal Zone for the last 18 years. He is a member of the American College of Hospital Administrators and a senior member of the American Association of Hospital Accountants.

Robert V. Fay has been appointed administrator of Community Memorial Hospital, Ayer, Mass. Prior to his new appointment, Mr. Fay was assistant administrator at Bridgeport Hospital, Bridgeport, Mass., where he also served his administrative residency. He is graduate of the Northwestern University course in hospital administration.

C. R. Rostomily

Clifford R. Rostomily has assumed the duties of administrator of Lawrence County General Hospital, Ironton, Ohio. Mr. Rostomily was formerly assistant superintendent of Cincinnati General Hospital. He is a graduate of the University of Minnesota course in hospital administration, and served his residency at St. Luke's Hospitals, Milwaukee. Mr. Rostomily succeeds **Edith V. Brown,** who will remain as assistant administrator.

Robert K. Adler has been named assistant director of the Jewish Hospital of Brooklyn, New York. Mr. Adler has served as medical social worker and administrative assistant at the hospital during the last six years. He holds a master's degree from the New York School of Social Work at Columbia University, with a specialization in community health organization and medical social work.

James O. Bremseth has been appointed assistant administrator of Marion General Hospital, Marion, Ind. Mr. Bremseth is a graduate of the program in hospital management of Washington University, St. Louis, and recently completed his residency at Hillcrest Hospital, Tulsa, Okla.

Mother M. Constance has been named administrator of Sacred Heart Hospital, Manchester, N.H. Mother Constance, formerly administrator of Our Lady of Perpetual Help Maternity Hospital, a division of Sacred Heart, succeeds **Sister Mary Davida.**

L. A. Ensminger

Leonard A. Ensminger is the new administrator of Torrance Memorial Hospital, Torrance, Calif., succeeding **Elsa Hammerstrom,** who has resigned. Prior to his appointment Mr. Ensminger served as administrator of San Gabriel Valley Hospital, San Gabriel, Calif. He is a graduate of the course in hospital administration at the University of California. He served an administrative internship at San Antonio Community Hospital, Upland, Calif., and a residency at the University of California Medical Center at Los Angeles.

George J. Riesz has been appointed administrative assistant and administrator of the outpatient department at New Mount Sinai Hospital, Toronto, Ont., upon the completion of his administrative residency there. Mr. Riesz is a graduate of the course in hospital administration at the University of Toronto.

Robert A. Patterson has been named administrator of the Campbell Memorial Hospital, Weatherford, Tex. He replaces **Marvin Harkins** who resigned.

H. W. Kilby has been appointed administrator of the Glynn Brunswick Memorial Hospital, Brunswick, Ga. He was formerly the business manager.

Dean H. Byrd, administrator of South Florida Baptist Hospital, Plant City, Fla., has been appointed administrator of the new Houston County Hospital, now under construction at Dothan, Ala.

Wallace W. Favorite has assumed the duties of administrator of Saline Memorial Hospital, Benton, Ark.

Department Heads

Grace Stumpf has been named director of dietetics at University Hospital, Columbus, Ohio. Miss Stumpf served as chief dietitian of a 1000 bed general hospital in Europe during World War II, and has since served as assistant chief dietitian at a veterans administration hospital in Los Angeles. Prior to her appointment, Miss Stumpf was chief of the dietetic service in the V.A. Hospital, Ann Arbor, Mich. She received her training at University Hospital, Ann Arbor, Mich.

Miscellaneous

Albert V. Whitehall, formerly director of Washington Blue Cross, Seattle, has been appointed associate director of health insurance for the Life Insurance Association of America, New York City. Before joining Blue Cross two years ago, Mr. Whitehall was director of the Washington Service Bureau of the American Hospital Association for several years.

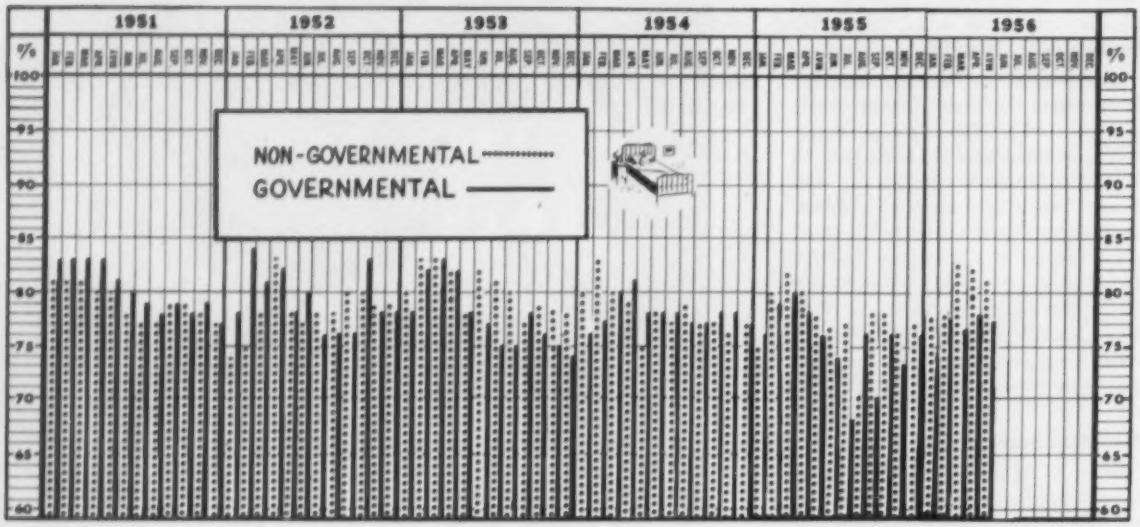
Deaths

William B. Hall, administrator of the University of California Hospital and H. C. Moffitt Hospital, both part of the University of California Medical Center, San Francisco, died at the age of 61. Mr. Hall was named assistant superintendent at the University of California Hospital in 1927, serving successively as business manager and superintendent there. In 1950, he also was named to the position of administrator for the new Moffitt Hospital, in addition to his other responsibilities.

Ellard Lake Slack, administrator of Samuel Merritt Hospital, Oakland, Calif., from 1928 to 1955, died at the hospital after a long illness. Mr. Slack had also served as administrator of Sutter Hospital in Sacramento, Calif., from 1923 to 1928. He was a charter fellow of the American College of Hospital Administrators, and held various offices, including that of president in the Association of Western Hospitals.

W. L. Gibbs, business manager at Central State Griffin Memorial Hospital, Norman, Okla. for the last 43 years, died after a serious illness of several months. Mr. Gibbs was also chairman of the board of Norman Municipal Hospital, Norman, Okla., for many years.

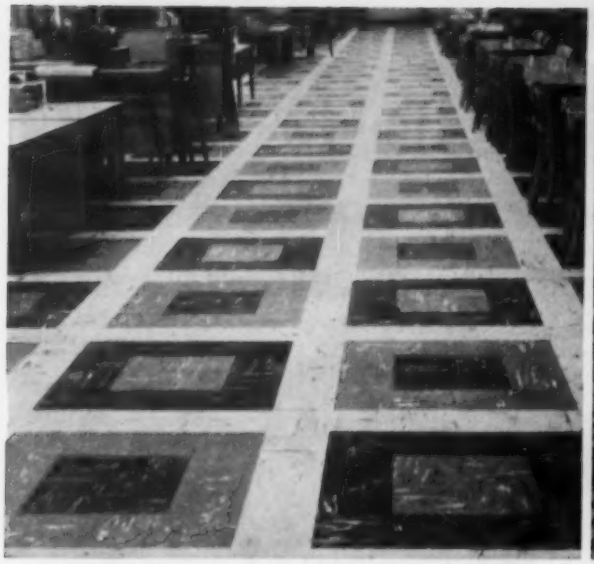
Voluntary Hospital Occupancy Rises in May



According to their reports to the Occupancy Chart, voluntary hospitals were 81.2 per cent occupied during the month of May. Reports from governmental hospitals indicated they were filled to 77.1 per cent of capacity. In May of last year, occupancies were 78.1 and 74.5 per cent, respectively.

Construction for the period April 30 through June 11 amounted to $107,097,821, bringing the year's building total to date to $367,708,261. Construction for the four-week period reported in this issue a year ago amounted to $44,057,579 and brought 1955's building total to $296,885,079. Of the 94 current projects, 25 are new hospitals, and 57 are additions.

So easy to care for... saves up to 50% on maintenance costs!



Despite constant exposure to heavy traffic and accidentally spilled food, the Terraflex floor in the Sperry Gyroscope Co. cafeteria at Lake Success, L. I., shows no sign of wear . . . still looks fresh and colorful.

More than a million people use the Miami Terminal of Eastern Airlines each year. After several years of service, Terraflex has proved its durability . . . still looks colorfully new . . . has cut maintenance time and costs.

Johns-Manville TERRAFLEX Vinyl Asbestos tile flooring . . . beautiful, colorful, incredibly durable!

ACTUAL ON-THE-JOB FIGURES show that Johns-Manville Terraflex® floor maintenance expense is reduced as much as 50%, when compared to the next most economically maintained resilient type flooring.

A quick damp mopping usually keeps Terraflex clean and bright . . . its nonporous surface requires no hard scrubbing . . . frequent waxing is eliminated. Despite heavy traffic service . . . spilled liquids and foods . . . abusive treatment, Terraflex retains its sparkling, new appearance.

J-M Terraflex vinyl asbestos tile, available in 17 attractive marbleized colors, is the ideal flooring for restaurants, public areas, schools, hospitals . . . wherever reliable floor service, long-wearing beauty and maintenance economy must be combined.

For complete information about Terraflex vinyl asbestos floor tile, write Johns-Manville, Box 158, New York 16, N. Y.

See "MEET THE PRESS" on NBC-TV, sponsored on alternate Sundays by Johns-Manville

Check these special TERRAFLEX advantages

✓ 1. *Lasts Longer*

Made of vinyl and asbestos, Terraflex will outwear any other type of resilient flooring of equal thickness.

✓ 2. *Easy to Clean*

Dirt can't penetrate Terraflex's nonporous surface. A swish of a damp mop keeps it shining bright.

✓ 3. *Maximum Service*

Terraflex defies kitchen oils and greases . . . strong soaps will not dull its lustre.

✓ 4. *Wide Color Range*

Terraflex comes in 17 marbleized colors that go all the way through the tile—won't wear off or wash out.

✓ 5. *Greater Resilience*

Terraflex is flexible, provides comfort and quiet underfoot . . . resists indentation.

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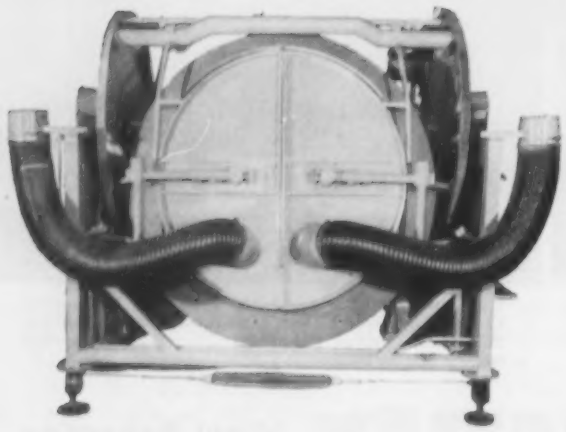
Johns-Manville

Purkett PCTs* have had to be good to serve these Hospitals without complaint



and the new 72" does a 50% still Better Job!

The sensational improvements in the new 72" PCT* make it positively essential for top operating efficiency in large flatwork and garment conditioning operations.

For example: You can now remove 20% moisture content in only 5 minutes tumbling time . . . you have 35% more heating coil surface (the 9-ring size is still available for those preferring it). New 8" vents eliminate the heat and lint output menace. The new 5" Blower is more powerful, delivering 1750 C.F.M. And you never saw such a stingy power user . . . only 7 B.H.P. per hour.

These and other features described in a new folder which will be sent gladly upon request. Purkett's Consulting Service is available without obligation to help you solve your conditioning problems.

***Pre-Drying Conditioning Tumbler.**

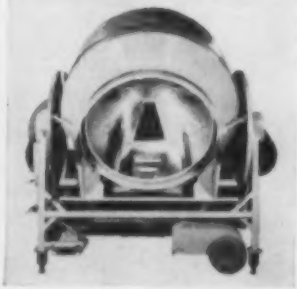
Naturally it's a PURKETT

PARTIAL LIST OF USERS OF PURKETT PRE-DRYING CONDITIONERS

Barnes Hospital	St. Louis, Mo.
DeWitt State Hospital	Auburn, Calif.
E. General & Orthopedic Hospital	Toronto, Ont.
Illinois Central Hospital	Chicago, Ill.
Lying-In Hospital	Chicago, Ill.
Long Island Hospital	Boston, Mass.
Menorah Medical Center	Kansas City, Mo.
Mercy Hospital	Sacramento, Calif.
Oak Park Hospital	Oak Park, Ill.
Pontiac State Hospital	Pontiac, Mich.
Presbyterian Hospital	Chicago, Ill.
Providence Hospital	Oakland, Calif.
St. Francis Hospital	Chicago, Ill.
Stratford General Hospital	Stratford, Ont.
St. Paul's Hospital	Vancouver, B. C.
St. Vincent's Hospital	Green Bay, Wis.
U. of Oregon Medical School	Portland, Ore.
Veteran's Hospital	Ft. Lyons, Colo.

and Many, MANY more satisfied Hospital users

35% more heating surface with the new 12-ring coil construction.



Unloading position shows powerful 5" Blower; also removable cleaning "door" to get to coils.

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POSITIONS WANTED

ADMINISTRATOR—45; presently employed, 50-bed institution; desires change; 30-bed hospital or larger; over 20 years extensive hospital experience and organization which included x-ray and clinical laboratories and anesthesia; past four years directed to completion 50-bed building program during which time hospital reached new levels of achievement as well as financial stability; location not a factor; references. Apply MW 106, The Modern Hospital, 919 N. Michigan, Chicago 11, Illinois.

ADMINISTRATOR—Fourteen years hospital administration experience presently employed as assistant administrator of Home and Hospital for the aged; will accept administrator's position in small hospital or home, and assistants position at a larger hospital; no objections to relocating. Apply MW 117, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ADMINISTRATOR—Male; 18 years experience including fund raising and hospital construction experience; Accounting Degree; will locate anywhere. Apply MW 118, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST — Desires position; AANA member; excellent training and experience; good ethical character; salary on fee basis; approved hospital, cultural living, moderate climate; combination executive duties considered. Apply MW 116, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

BUSINESS MANAGER or ASSISTANT ADMINISTRATOR—Young man, college graduate with six years hospital experience as business manager and accountant is desirous of relocating in a similar capacity or as an assistant administrator; location is not a factor. Apply MW 103, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR—8 years, Methodist clergyman; 2 years, public relations, 5 years, assistant, director, 600-bed teaching hospital; 3 years, director, 80-bed hospital; must return to Massachusetts account aged parents; middle 40's; excellent recommendations; Nominee ACHA.

ADMINISTRATOR—Medical; 5 years, medical director, university hospital; FACHA.

ANESTHESIOLOGIST—Diplomate; 2 years, associate anesthesiologist, large teaching hospital; now ready for own department, any locality.

COMPTROLLER—3 yrs., traveling auditor; 2 yrs., comptroller, large hosp.; Canadian; feels opportunities would be better in United States.

WOODWARD—*Continued*

PATHOLOGIST—Diplomate, pathologic anatomy, clinical pathology; 4 years, associate pathologist, 600-bed teaching hospital; qualified radioisotopes, hematology.

PURCHASING DIRECTOR—10 years, purchasing director, 700-bed university hospital; eminently qualified; recommended without reservations.

RADIOLOGIST — Diplomate, therapy, diagnosis, radium; 8 years, professor and director, radiology, medical school and its graduate hospital; well qualified, oncology; outstanding specialist of highest order.

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PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR—Medical, M.P.H., Hospital Administration; M.S., Health and Physical Education; eight years, assistant superintendent, 1200-bed general hospital; three years, administrative staff, one of leading organizations in graduate medicine.

ADMINISTRATOR—A.B., M.Ed., Ph.Ed.; four years' experience, public relations, fund raising; six years, assistant superintendent, 700-bed general hospital, university affiliations; member ACHA.

ADMINISTRATOR—Professional nurse; B.S., Education; M.S., Hospital Administration; seven years' teaching experience; two years superintendent, 150-bed hospital.

ANESTHESIOLOGIST — University hospital training in anesthesiology; two years, associate in anesthesiology; teaching hospital; five years' group practice; Diplomate.

COMPTROLLER—Eight years, chief accountant and business office manager, university hospital, 800-beds.

PATHOLOGIST—Five years' training, teaching hospital; three years, associate pathologist, 600-bed university hospital; Diplomate; F.A.C.P.

PERSONNEL DIRECTOR—A.B., considerable work toward MBA, personnel management; six years' hospital personnel experience.

PURCHASING DIRECTOR — B.S. Business Administration; six years, assistant administrator in charge of purchasing, 200-bed hospital.

RADIOLOGIST—University hospital training in radiology including radioisotopes; M.S., radiology; four years, group association; Diplomate, Diagnostic and Therapeutic Radiology.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director

332 Bulkley Building

Cleveland, Ohio

ASSISTANT DIRECTOR — Degree, Social Sciences; M.H.A. Degree, 1953; past two years assistant administrator, 250-bed institution; available.

(Continued on page 178)

INTERSTATE—*Continued*

COMPTROLLER, or BUSINESS MANAGER —Age, 22 years; Degree in Accounting; 7 years office manager; 4 years comptroller, 450-bed Ohio hospital.

ADMINISTRATOR—F.A.C.H.A.; 14 years experience, 300-bed Ohio hospital; 5 years, 200-bed hospital, south; completed expansion programs.

ASSISTANT DIRECTOR — M.H.A. Degree; doctorate studies school of public health; 3 years assistant director, 150-bed eastern hospital; prefers large medical center; available September.

EXECUTIVE HOUSEKEEPER—College education; 2 months course hospital housekeeping; 10 years hotel experience; past 6 years head housekeeper, progressive 350-bed mid-western hospital; prefers change.

X-RAY TECHNICIAN—Chief, registered; 2 years supervisory experience, 750-bed hospital.

POSITIONS OPEN

ANESTHETIST—Registered nurse; modern 112-bed hospital; active medical staff; friendly community. Apply Alan B. Campbell, Administrator, Richland Memorial Hospital, Olney, Illinois.

ANESTHETISTS—Nurse; two; 250-bed hospital; department supervised by M.D.; emergency call alternated every fourth day; starting salary $450 per month. Apply St. Francis Hospital, Monroe, Louisiana.

ANESTHETISTS — Nurse for 155-bed modern general hospital; air conditioned work areas; good personnel program; remuneration $5,000-$6,500. Call or write Administrator Midland Hospital, Midland, Michigan.

ANESTHETISTS—3 nurse anesthetists to increase staff; approved A.A.N.A. training school; good working conditions; medical anesthesiologist in charge of department. Apply Director, Department of Anesthesiology, Lancaster General Hospital, Lancaster, Pennsylvania.

ANESTHETISTS—Nurse; modern 400-bed hospital; staff of 5 nurse anesthetists and 1 anesthesiologist; salary up to $400 and other benefits; For particulars contact Vincent A. Kehm, M.D., Chief Anesthesia, York Hospital, York, Pennsylvania.

ANESTHETIST—Nurse; capable of administering anesthesia for chest surgery; 150-bed tuberculosis hospital; comparatively light work load, salary open, attractive stipend, temporary or permanent. Write Paul W. Nelson, M.H.A., Administrator, Seward Sanatorium, Bartlett, Alaska.

ANESTHETIST—Nurse; 100-bed hospital; new hospital being constructed; salary open. Apply Nathan I. Kantor, M.D., Chief Anesthetist, Warren Hospital, Philipsburg, New Jersey.

ANESTHETIST—Position open in 200-bed hospital in Minot, North Dakota; salary according to qualifications; not less than $400.00 per month plus maintenance; 4 weeks vacation, 40 hour week. For further information write to Trinity Hospital, Minot, North Dakota.

classified advertising

POSITIONS OPEN

ANESTHETISTS—Nurse; two required; immediately for 250-bed general hospital; modern, accredited, standard hospital personnel policies, fine community adjacent to Cleveland; salary open; full maintenance available. Apply Miss Ines Ealy, R.N., Anesthesia Department, The Elyria Memorial Hospital, Elyria, Ohio.

ASSISTANT DIRECTOR IN NURSING EDUCATION—Diploma program with university affiliation for teaching of basic sciences; 150 students; very good personnel policies and pleasant working conditions; opportunity for leadership and initiative; adequate academic preparation and successful experience required. Write Director, School of Nursing, St. Luke's Hospital School of Nursing, Duluth, Minnesota.

ASSOCIATE DIRECTOR, NURSING SERVICE: Responsible for nursing service in 400-bed non-profit hospital which includes 115-bed pediatric unit; friendly city 225,000; prefer candidate with successful experience and preparation in nursing administration; 40 hour week; salary open; position available July 1, 1956. Apply Director of Nursing Service, Iowa Methodist Hospital, Des Moines, Iowa.

DIETITIAN—Assistant; 160-hospital, 40 miles west of Philadelphia, serving 50,000 population, also school for student nurses; salary open. Apply MO 141, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Assistant to director of department; small hospital, New York State; teaching and therapeutic duties; unusual fringe benefits; salary open. Apply MO 139, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Registered chief; 110-bed general hospital; duties involve therapeutic diet planning, patient contact, general supervising; salary open. Contact M. I. Clement, Saratoga General Hospital, 15000 Gratiot Avenue, Detroit 5, Michigan.

DIETITIANS — Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Chief; 450-bed voluntary general hospital, large diabetic service, has immediate opening for experienced chief dietitian; duties include supervising dietary department; remodeling department in near future; salary open. Address letters of application to The Administrator, Good Samaritan Hospital, Portland, Oregon.

DIETITIAN—A.D.A.; 310-bed general hospital; East Coast. Apply Administrator, St. Joseph's Hospital, Providence, Rhode Island.

DIETITIANS—Urgently required for the British Columbia Civil Service in Government hospitals in the Vancouver-New Westminster area; salary $250-$305 per month; permanent positions for British Subjects; generous holiday and sick leave, superannuation plan; ample recreational facilities; must be graduates of a recognized school of dietetics. Apply to the Personnel Officer, British Columbia Civil Service Commission, Essondale, B.C., Canada.

DIETITIAN—Assistant; registered, 210-bed hospital; duties involve therapeutic diet planning and assisting administrative dietitian, general supervising; salary open; 44 hour week; 2 week paid vacation; 6 holidays; school of nursing. Apply Director of Personnel, Sioux Valley Hospital, Sioux Falls, South Dakota.

DIETITIAN—Assistant to chief; 160-bed general hospital; college town of 25,000, 20 miles west of Milwaukee; modern dietary department completely remodeled in 1955. Write Robert M. Jones, Administrator, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR OF NURSING—General voluntary hospital with bed capacity after expansion in near future of approximately 325 including bassinets, with diploma school of nursing; all approvals and all regular services; salary open; attractive separate residence; total responsibility for nursing service and school, reporting directly to administrator; age preferably above 30 and with progressive attitude; desire M.A. in Nursing Education or Nursing Administration and 3 years suitable experience, including supervision and nursing service administration in hospital with professional school, or reasonable equivalent; southern New England. Apply MO 126, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSES—Very modern hospital, popular resort area, excellent opportunity, full responsibility; supervisory experience required; salary dependent on qualifications, about $5,000; full interview expense by arrangement. Contact Administrator, Schoolcraft Memorial Hospital, Manistique, Michigan.

DIRECTOR OF NURSES—Experienced; new 71-bed hospital; social security; 44 hours a week; salary open; city population 18,000. Apply Administrator, Morristown-Hamblen Hospital, Morristown, Tennessee.

EDUCATIONAL DIRECTOR—204-bed private general hospital; enrollment 75 students; school has temporary national accreditation; new classes in September; degree preparation and experience necessary; salary open. Apply Director of Nurses, Lewis-Gale Hospital, Roanoke, Virginia.

INSTRUCTOR—Psychiatric nursing; B.S. degree required; experience not necessary; $3300 beginning salary plus complete maintenance; progressive state hospital with affiliate program. Contact Personnel Director, Box 111, Independence, Iowa.

INSTRUCTOR—Clinical; medical and surgical divisions of 400-bed hospital with large school of nursing. Apply Director of Nurses, Evangelical Deaconess Hospital, St. Louis 10, Missouri.

INSTRUCTOR—Medical clinical; opening available July '56; liberal personnel policies; 40 hour week, 28 days vacation, 8 paid holidays, 18 miles from New York City; live in if desired; new ultra-modern 250-bed hospital will be completed in April 1957. Apply Director of Nurses, Clara Maass Memorial Hospital, 12th Avenue & Newton Street, Newark, New Jersey.

INSTRUCTOR—Nursing arts; opening available August '56; salary commensurate with education and experience, 40 hour week, 28 days vacation, 8 paid holidays; 18 miles from New York City; live in if desired; new ultra-modern 250-bed hospital will be completed in April 1957. Apply Director of Nurses, Clara Maass Memorial Hospital, 12th Avenue & Newton Street, Newark, New Jersey.

(Continued on page 180)

INSTRUCTOR—Nursing arts; 50 to 75 students, 140-bed hospital. Apply Director of Nursing, St. Mary's Hospital, Orange, New Jersey.

INSTRUCTOR—Clinical; medical and surgical nursing, fully accredited school attached to 400-bed, general hospital, 25 minutes from Times Square, staff or head nurse experience, B.S. preferred; liberal personnel policies. Apply Personnel Director, The Brooklyn Hospital, 121 DeKalb Avenue, Brooklyn 1, New York.

INSTRUCTOR FOR NURSES' AIDES—General hospital treating men, women and children; 128 adult and pediatric beds plus 24 bassinets; 40 hour week; salary open. Apply Director, Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

LAUNDRY MANAGER—for 300-bed midwest teaching hospital; formal laundry management training preferred but will consider applicant who has served as assistant in recognized hospital laundry. Ability to manage laundry personnel essential. Apply MO 140, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIANS—Medical records; basic knowledge modern medical records, methods and techniques; must be registered; new hospitals in Kentucky, Virginia, and West Virginia; good personnel policies, including forty hour work week, four week paid vacation, non-contributory retirement plan. Please send applications to Mr. Philip J. Olin, Miners Memorial Hospital Association, 1427 "I" Street, N.W., Washington 5, D. C.

LIBRARIAN—Assistant medical record; registered or eligible; 300-bed general hospital; merging with 2 other hospitals in 800-bed Center next year; salary open. Contact Personnel Officer, Garfield Memorial Hospital, Washington, D.C.

LIBRARIAN—Registered medical record; 250-bed hospital located on bank of the Hudson; unit system and standard nomenclature; competent record room staff; air conditioned office, 40 hour week, 1 month vacation and liberal sick benefits; substantial salary. Apply, Vassar Brothers Hospital, Poughkeepsie, New York.

LIBRARIAN—Medical record; registered; to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

MISCELLANEOUS—Dietitian (1) and Nursing Arts Instructor (1) of 110-bed hospital. Apply Superintendent, The Charlotte County Hospital, St. Stephen, New Brunswick, Canada.

NURSES—General duty; 7 to 3 and 3 to 11 shifts; 40 hour week, 50-bed hospital, good personnel policies, salary open; in Michigan's beautiful north country; popular winter and summer sports in Petoskey, Michigan. Apply MO 134, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

NURSES—Florida; take advantage of Florida's sunshine and pleasant living; Jacksonville's rapid growth has created a need for more hospital beds. Registered nurses are needed for surgical obstetrical and general duty; modern 375-bed general hospital on the beautiful St. John's River; basic salary $241.00 per month with increments for evening and night duty and for surgical nursing; 40 hour week. Apply Director of Nursing Services, St. Vincent's Hospital, Jacksonville, Florida.

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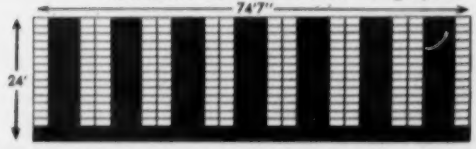
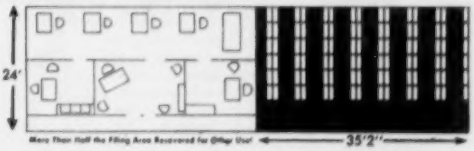
Floor Plan of an Actual Filing Area Before Installation of the Visi-Shelf Filing System



This area was occupied by 196 four drawer letter filing cabinets with a filing capacity of 784 drawers or 20,776 filing inches.

Floor Plan after Installation of the Visi-Shelf Filing System



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NURSES—Graduate; for 64-bed private hospital and clinic, near San Francisco; close proximity to vacation areas. Write Director of Nurses, Woodland Clinic Hospital, Woodland, California.

NURSES—Graduate; two; if interested contact Medical Director, Florida State Hospital, Arcadia, Florida.

NURSES—Operating room; male and female; immediate appointments for staff and head nurses in medical center; all types of special surgery; 30 days vacation, 8 paid holidays; staff nurses—$320 to $335 per month; head nurses $335 to $375; evening duty differential $40; night duty $30. Write to Associate Director, Nursing Service, Michael Reese Hospital Medical Center, Chicago 16, Illinois.

NURSES—Operating room; for teaching hospital within walking distance of teachers college; salaries and personnel policies comparable to other hospitals in area. Write Director of Nursing, Box P, St. Luke's Hospital, New York 25, N.Y.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered operating room; staff positions in 400-bed, teaching hospital, 25 minutes from Times Square; salary $270-$290 per month; 5 days, 40 hour week; 4 weeks vacation; 21 sick days, 7 holidays. Apply Personnel Officer, The Brooklyn Hospital, 121 DeKalb Avenue, Brooklyn 1, New York.

NURSES—Registered; there are positions open for staff and assistant head nurses in the new 277-bed University of Oregon Medical School Hospital in Portland, Oregon; arrangements may be made for attending classes on campus which lead to baccalaureate or masters degrees in nursing. For full information write to Director of Nursing Service.

NURSES—Registered general duty; for 195-bed general hospital in pediatric, medical and surgical wards; pharmacy. Apply Superintendent, Hotel Dieu Hospital, Campbellton, New Brunswick.

NURSES—Registered; for general staff duty in 53-bed general hospital, air conditioned; located 25 miles from Texas coast; population 50,000; 44 hour week, 2 weeks paid vacation, 3 weeks after 5 years, 6 paid holidays, liberal personnel policies; salary open. Write or call, Mrs. Hazel Woods Riddle, R.N. Director of Nurses, DeTar Memorial Hospital, Victoria, Texas.

NURSES—Registered; salary $225 per month gross; 5 day week; single room residence, 20 miles east of Toronto. Apply Superintendent, Ajax & Pickering General Hospital, Ajax, Ontario, Canada.

NURSES—Staff; 51-bed well equipped modern hospital; beginning salary $270, 40 hour week, differential for evenings, nights and special training; located on Hiway 99 half-way Seattle and Vancouver, B.C., scenic, sports, fishing, hunting. Apply Administrator, Memorial Hospital, Sedro Woolley, Washington.

PHYSICAL THERAPIST — 200-bed general hospital; moving department to new quarters; $4200, meals and quarters and laundry to start. Apply MO 142, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

SANATORIA DIETARY CONSULTANT — for the State of Maine Department of Health and Welfare; new opportunity resulting from transfer of three TB sanatoria; salary scale, $4264 to $5304, based on experience, plus mileage and expenses; all the customary state personnel department advantages of paid sick and vacation leave, 40 hour week, retirement, paid holidays, etc.; education and experience must be equivalent to qualifications for membership or eligibility for same in American Dietetic Association; for more complete details and application forms, please write to Personnel Officer, State Department of Health and Welfare, Augusta, Maine.

SUPERINTENDENT OF NURSES—150-bed general hospital; fully approved by Joint Commission on Accreditation; metropolitan area, northeast Ohio; suitable experience required no training school; salary open. Apply MO 133, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISOR—Obstetrics; post graduate work in obstetrics and supervisory experience required; immediate opening; modern and up-to-date department; social security and excellent personnel benefits. Apply Director of Personnel, White Cross Hospital, 700 North Park Street, Columbus 8, Ohio.

SUPERVISOR—Operating room; modern 400-bed hospital; well qualified person needed; salary commensurate with experience; liberal personnel policies. Apply Superintendent of Nurses, York Hospital, York, Pennsylvania.

TECHNOLOGIST—Clinical laboratory; male or female; applicants holding California license for laboratory technician given preference; paid call duty, 40 hour week; starting salary up to $315.00 for qualified unlicensed personnel; up to $350.00 for licensed personnel; fully approved 130-bed JCAH hospital operated in conjunction with large clinic. Apply A. G. Turner, Administrator, Kaiser Foundation Hospital, 9961 Sierra Avenue, Fontana, California.

TECHNICIAN—Laboratory; 125-bed hospital; excellent positions open for two clinical laboratory technicians who will qualify for the California Board; salary open; one month's vacation with pay, transportation expenses reimbursed if satisfactory. Communicate San Antonio Community Hospital, Upland, California.

(Continued on page 182)

TECHNICIAN—General laboratory; male or female. Apply MO 135, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

TECHNICIAN—Laboratory; eligible for California license, for 75-bed hospital; very desirable location on Monterey Bay; generous personnel policies; salary open. Contact Laboratory Director, Watsonville Community Hospital, Watsonville, California.

TECHNOLOGIST—Medical; preferably M.T. (A.S.C.P.) for 200-bed hospital in college town; rotating service; new laboratory; good personnel policies. Apply Middlesex Memorial Hospital Laboratory, Middletown, Connecticut.

TECHNICIAN—Combination laboratory and X-ray wanted now; with at least 2 or 3 years experience; to be in charge both departments; one other technician employed; beginning salary $400.00 but varying with qualifications. Contact Esther M. Squire, Administrator, Murphy Memorial Hospital, Red Oak, Iowa.

TECHNICIAN—Laboratory, X-Ray; immediately for small approved hospital; 5 day week; working conditions and salary excellent. Apply Administrator, St. John's Hospital, Jackson, Wyoming.

TECHNICIAN—X-ray and laboratory; for 50-bed fully modern Municipal Hospital; town of 2500; new nurses' residence; salary commensurate with ability and experience. Apply J. A. Bloom, Secretary-Treasurer, Municipal Hospital, Hanna, Alta., Canada.

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ADMINISTRATORS — (a) Medical director and assistant medical director; county hospital; duties, direct hospital and clinical program; $900 and $750, homes, utilities; California. (b) University affiliated hospital, 275-beds; offer sufficiently attractive to interest man of outstanding qualifications; midwest. (c) Voluntary general hospital, 300-beds relatively new; college town, south. (d) New 110-bed hospital, general, currently under construction; east. (e) New 50-bed general hospital; one qualified undertake full responsibility; $8000-$10,000; California. (f) New general hospital, 50-beds; college town, Florida; professional nurse eligible. (g) Executive secretary; state hospital association; $7000-$10,000. (h) Assistant superintendent; municipal hospital, 2000-beds; second-in-command; university city, east. (i) Assistant; new general hospital; university affiliated; currently 200-beds expanding to 450; teaching center, south. (j) Assistant; pediatric hospital, 250-beds, unit university group; Master's in Hospital Administration, accounting experience desired; $6000-$9000; east. (k) Assistant; 900-bed general hospital, city owned, affiliated medical school; accounting background, 3 years' experience required, if Master's, one year; midwest. (l) Associate Administrator (man) qualified succeed administrator and administrative assistant (woman); 350-bed hospital; 275 employes; university city, midwest. (m) Nurse administrator to serve as consultant new hospital, 30-beds; equip. staff, operates; rural, Missouri.

ANESTHETISTS—(a) 70-bed hospital opens August; scenic resort area, southwest; to $6600. (b) Small hospital, expansion plans to 80; beautiful lake region, south; $500 plus ½ night fees. (c) Staff; Pacific Island hospital;

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

American Naval Station; ideal climate. (d) New modern 50-bed hospital; latest equipment; wealthy rural area; midwest; $7200. (e) Two; well established 40 man clinic; exceptional opportunity; minimum $500; midwest.

DIETITIANS—(a) Chief; reorganize, direct, dietary department, 700-bed hospital, near New York City; all modern facilities. (b) Food production manager; 400-bed general hospital; provide consultative services, overall supervisory department; top salary; midwest.

DIRECTORS OF NURSES—(a) Director of nursing service; outstanding 350-bed university hospital; faculty status; full complement of nurses; ideal West Coast location; $6600. (b) Director service and education; 250-bed general hospital; well organized staff; 100 students, accredited school; near leading ocean city; minimum $6000, maintenance. (c) Principal, school of nursing; 225-bed renowned hospital; school of 125, college affiliated; Pacific Northwest; minimum $6000, penthouse apartment. (d) Director service; responsible in-service program; modern Alaska city; to $7800. (e) Director of nurses; 50-bed hospital, expansion plans; excellent opportunity; New York; $5000.

EXECUTIVE HOUSEKEEPER—200-bed hospital near New York City; 25 in department; $2½ million expansion; reorganization program.

EXECUTIVE PERSONNEL—(a) Accountant; supervisory position; 500-bed general hospital; large city, midwest. (b) Clinic manager; 12 men; college town, west. (c) Credit manager; new 200-bed general hospital; college town, west. (d) Food service manager; traveling consultant to state institutions, southwest, $6300. (e) Personnel director; voluntary general hospital, 500-beds; university city, midwest. (f) Public relations director; top management job; major teaching hospital, progressive medical center, east. (g) Purchasing director; voluntary general hospital, 450-beds, California.

FACULTY POSTS—(a) Education director; school of 250, college affiliated; 600-bed hospital, northwest; start $7200. (b) Two medical-surgical instructors; one, supervise field experienced graduate students; one, teach in collegiate basic program; university school; east; $500 month, academic year. (c) Nursing school instructor; Pacific Island; American Naval Station; scenic beaches; exceptional recreational facilities; $4800, transportation.

RECORD LIBRARIANS—(a) Chief; noted 400-bed teaching hospital; cosmopolitan city outside United States; equable climate; maximum 89°; minimum 54°; $5000. (b) Chief; 400-bed hospital, affiliated medical school; excellent opportunity; east; $5-6000. (c) Director department of eight; 370-bed hospital; ideal southern California locations; $5000.

SUPERVISORS—(a) Floor Supervisor; direct nursing service 50-bed hospital; city of 10,000; New York, $5000. (b) Pediatric, obstetric, orthopedic, 250-bed hospital; Greater Manhattan; excellent educational opportunities; to $4900. (c) Obstetrical, American-owned industrial hospital, Asia; $9200, paid air travel via Paris, Rome.

ADMINISTRATORS — (a) Outside United States continental limits; complete study, operation, numerous hospitals preparatory to transfer operations to Public Health Department; travel as required. (b) General hospital, 300-beds; lovely town 60,000, university center; south. (c) Voluntary, general hospital, JCAH, medium size; on Hudson River; $8-$10,000. (d) General hospital fairly large size; vicinity, San Francisco. (e) Coordinator of Medical Education; newly created post; voluntary general hospital 450-beds; midwest. (f) Under construction; general hospital 100-beds; delightful, year-round warm climate; southeast. (g) Mature, experienced, with ample ability in public relations; general hospital, medium size; South Atlantic States.

ADMINISTRATORS—Assistants; (h) General voluntary hospital fairly large size; teaching program; $8000; large city on Lake Michigan. (i) Teaching hospital, 750-beds; $7500; large city, university center; midsouth. (j) Newly created post; general voluntary hospital, 350-beds; important city, university medical center; mideast. (k) Administrative assistant; complete charge, evening service; 3:00 P.M.-midnight; Monday through Friday; teaching hospital, 600-beds; central.

ADMINISTRATIVE POSTS—(a) Accountant; teaching hospital 500-beds; about $5000; near Detroit. (b) Business manager; to $7500; 300-bed general hospital; south. (c) Business manager; fairly large group; own 50-bed hospital; California. (d) Clinic manager; assistant; 16 man group; San Francisco area. (e) Credit manager; General voluntary hospital expanding to 500-beds; Kansas. (f) Comptroller; general voluntary hospital 175-beds; New England. (g) Assistant comptroller; C.P.A. for newly created post; general voluntary hospital, 300-beds; will eventually succeed to comptroller; large city on Lake Michigan. (h) Personnel director; general voluntary hospital 200-beds; $6000 minimum; university city; on Lake Michigan. (i) General voluntary hospital 300-beds expanding to 500-beds; university city on Lake Erie. (j) Personnel director; voluntary general hospital, fully approved, 300-beds; town 40,000; Pacific Northwest. (k) Public relations director; full responsibility, all mediums; 400-bed, medical school affiliated hospital; east. (l) Purchasing director; voluntary general hospital, medium size; Colorado.

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ACCOUNTANT—Office manager; (a) 200-bed eastern hospital. (b) Large Ohio clinic; $400.

ADMINISTRATOR — (a) 250-bed southern hospital. (b) 50-bed hospital, Florida. (c) 85-bed hospital, Pennsylvania; new 110-bed hospital planned. (d) 325-bed hospital, west coast. (e) New 50-bed hospital, California. (f) 60 bed midwestern hospital. (g) 60-bed Virginia hospital.

(Continued on page 184)

INTERSTATE—*Continued*

ADMINISTRATIVE ASSISTANT—(a) 375-bed specialized hospital; large industrial city; $685. (b) Director, public relations; outstanding large eastern hospital. (c) 180-bed Kentucky hospital.

PERSONNEL DIRECTOR—275-bed hospital, west.

DIRECTOR OF NURSING—(a) 300-bed hospital, east. (b) 275-bed Ohio hospital. (c) 185-bed southwest. (d) 225-bed hospital, south (e) Educational directors; Instructors—all specialities.

MEDICAL RECORD LIBRARIAN—(a) 350-bed hospital, Ohio, $5700. (b) 275-bed hospital, midwestern city; $500.

ANESTHETISTS—(a) $500, meals. (b) Pharmacists; to $450. (c) Technicians, laboratory, X-ray; Ohio, Michigan, south.

EXECUTIVE HOUSEKEEPER—(a) 240-bed hospital, Conn. (b) 150-bed hospital, $350, Florida. (c) 200-bed hospital, southwest. (d) Northwestern hosp.

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DIETITIANS—(a) Chief; middle west; 150-bed hospital; 24 in department; located in pleasant college town; $6000 up. (b) Therapeutic; middle west; 100-bed hospital; 11 employees in department; $385-425. (c) South; supervision of general and special diets and employees cafeteria; some teaching; 35 employees in department; 200-bed hospital in city of 32,000; $400. (d) Therapeutic; middle west; 300-bed hospital; staff of 5 dietitians and 5 food supervisors; duties writing of modified diets and relieving floor dietitian in supervision of tray service; $4200.

PHARMACISTS—(a) Chief; middle west; 200-bed general hospital, fully approved; $5400-$6000. (b) South; assistant; 3 in department; 300-bed hospital in large southern city; $5000. (c) Middle west; 70-bed hospital; some administrative work; purchasing optional; $5400. (d) East; staff; large hospital affiliated with university, 6 pharmacists in department. (e) Chief; middle west; 350-bed hospital in city of 60,000; $520. (f) Southwest; 250-bed general hospital in city of 100,000; $5000.

MEDICAL TECHNOLOGISTS—(a) California; 160-bed hospital with a very active clinical laboratory; $375. (b) Department of medicine in large university; research work; training in chemistry and bacteriology; $400. (c) East; 300-bed hospital with a well equipped and staffed laboratory; $400. (d) Middle west; 250-bed hospital; 10 employees in department directed by 2 certified pathologists; $400. (e) Southeast; 200-bed hospital; laboratory well equipped under direction of certified pathologist; to $450. (f) East; 175-bed hospital; 4 technicians in laboratory; wide range of tests; $5000. (g) South west; modernly equipped private laboratory; require good knowledge of all general laboratory technique; $400.

MEDICAL RECORD LIBRARIANS — (a) South; 150-bed hospital; 4 in department; good experience coding and indexing; $4800. (b) Middle west; chief; 2 medical stenographers and 2 file clerks in department; 185-bed hospital; $5400. (c) East; chief; 14 employees in department, all well trained and dependable; 300-bed teaching hospital; $5400. (d) Chief; middle west; 600-bed hospital; good experience with standard nomenclature; staff of five in department; $5300. (e) Pacific Northwest; department has 10 full time employees and uses standard nomenclature and unit system of filing; $4200. (f) East; chief; 350-bed teaching hospital; $5100.

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(Continued on page 186)

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For complete information write: Director of Nursing Service, University of Oregon Medical School Hospital, 3181 S. W. Sam Jackson Park Road, Portland 1, Oregon.

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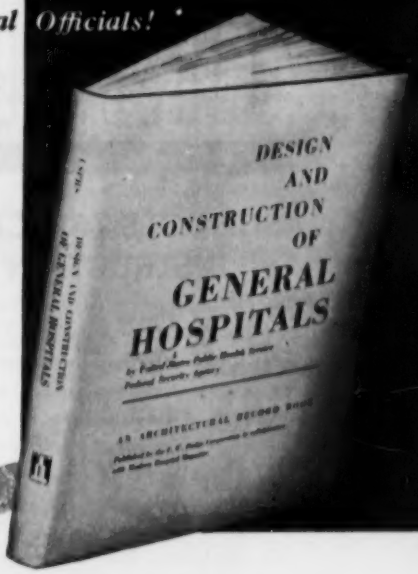

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- B. Nursing Facilities
  - Patient Areas
  - Two-bed Rooms
  - Four-bed Rooms
  - Isolation Units
  - Psychiatric Room
  - Treatment Room
  - Nurses' Station
  - Consultation Room
  - Utility Room
  - Floor Pantry
- C. Surgical Facilities
  - Operating Rooms
  - Sub-sterling Rooms
  - Scrub-up Facilities
  - Clean-up Room
  - Anesthesia Equipment Room
  - Cystoscopic Room
  - Fracture Room (Orthopedic)
  - Laboratory
  - Darkroom
  - Instrument Room
  - Surgical Supervisor's Office
  - Doctors' Locker Room
  - Nurses' Locker Room
  - Closets
  - Corridor
  - Central Supply Facilities
- D. Obstetrical Facilities
  - Delivery Rooms
  - Treatment Rooms
  - Supply Closet
  - Labor Rooms

IV. EQUIPMENT AND SUPPLY LISTS

10-day Free Examination Privilege

Dodge Books
119 West 40th Street, New York 18, N. Y.

Please send me for 10 days FREE EXAMINATION a copy of "Design and Construction of General Hospitals." Within 10 days I will either send payment for $12.00, plus postage, or return the book without obligation.

NAME .....

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Save Postage: If payment accompanies this order, we pay all handling and postage charges. Same return privilege.

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Ill.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

NEW YORK UNIVERSITY offers to qualified registered nurses, who meet admission requirements of the Department of Nurse Education, School of Education, a one year's internship in Clinical Nursing at James Ewing Hospital of the Department of Hospitals, Memorial Center. Experiences include cancer chemotherapy, medicine, surgery, rehabilitation and principles of team nursing. A monthly stipend, laundry and two meals a day are provided. Students will be assisted in securing desirable living accommodations. Classes are accepted in February and September. For further information write to Rosemary Bouchard, Director of the Internship Program, Department of Nurse Education, School of Education, New York University, Washington Square, New York 3, New York.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 200. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Resuscitator-Inhalator is Pocket Sized

The new Western Reserve Resuscitator-Inhalator is a completely portable

unit, both as to the machine itself and the oxygen cylinders. Two thumb sized oxygen cylinders are attached to the unit and contain sufficient oxygen for 10 to 15 minutes use. The oxygen is released into the rebreathing bag in a matter of seconds. Thus the unit, which has a total weight of less than two pounds, is especially useful for emergencies, either in the patient's room, in the emergency room or wherever it can be quickly reached. The units are low in cost and easy to store, hence they can be kept readily available at nurses' stations or in other central areas on each floor. Where continued use of oxygen is necessary, the Western Reserve can be attached to a large oxygen tank with conventional regulator.

The Western Reserve Anesthesia Unit is equipped to accommodate midget cylinders of cyclopropane in non-explosive mixture with oxygen and helium. It can be used in obstetrical deliveries, for setting simple fractures to supplement nerve block and spinal anesthesia and for many other needs in the hospital. It is equipped with every safety device with all rubber and metal parts conductive, cylinders colored to indicate contents and an automatic release valve to prevent too great lung pressure. The unit was developed by Robert A. Hingson, M.D., Director of Anesthesia, Western Reserve University, Cleveland, in cooperation with other authorities, and has been extensively tested clinically. **Continental Hospital Service, Inc., 18624 Detroit Ave., Cleveland 7, Ohio.**

For more details circle #210 on mailing card.

Pad Dispenser for Maternity Ward

Thirty No. 659 twelve inch Kotex Maternity Pads are dispensed from the new all-metal dispenser designed for use in hospital obstetrical wards. Constructed of 24 and 48 gauge reenforced steel, it is finished in white enamel. It is 13 inches high, 11⅜ inches wide and 9½ inches deep. It is restocked by lifting the full width front cover and pads are dispensed from any one of three channels. The unit is designed for use by ambulatory patients and is easily mounted in lavatory, ward or nursing station. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #211 on mailing card.

Improved Croupette for "Cool-Vapor" Therapy

Several new features have been incorporated into the new Model D Croupette. An indicating gauge to ensure the proper pressure eliminates guesswork and the possibility of poor operation due to faulty or inaccurate flowmeters. All operating instructions are printed right on the Plexiglas of the Croupette with

separate, legible panels at every point to ensure accurate operation without delay or guessing.

The new stainless steel atomizing assembly is designed for the life of the unit and is easy to clean, durable and adaptable to all models of the Croupette. The new wide mouth standard glass water jar provides easy access to the atomizing assembly. It can be readily replaced and cleaning and filling are simplified by the wide opening. The canopy is of heavy 6 mil material with reenforced seams and zippers. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #212 on mailing card.

(Continued on page 188)

Blood Lancet Is Disposable

Blood sampling procedures are speeded with the new sterile, disposable blood

lancet, known as Redi-Lance. At the same time the Redi-Lance acts as a safeguard against transmission of infectious disease. It is steam sterilized after being individually packaged and remains sterile until the package is opened, when it is ready for immediate use. Once used the Redi-Lance is discarded, removing any possibility of transmitting virus hepatitis and hemolytic jaundice in blood sampling. It is made of stainless steel, shaped to fit the contours of the fingers, and has a razor-sharp point. **Clay-Adams, Inc., 141 E. 25th St., New York 10.**

For more details circle #213 on mailing card.

Plumbing Fixtures Fill Special Needs

Four new hospital fixtures have been introduced by Crane. They include a surgeon's lavatory and instrument tray with a knee-action mixing valve; a laboratory sink equipped with indexed, wrist-action blade handles; an all purpose sink with floor-mounted double pedal mixing valve, and a surgeon's wash-up and instrument tray with wrist-action blade handles.

The new line is constructed of Crane-patented Duraclay, a vitreous glazed earthenware which expands and contracts under extreme temperature changes without cracking. All fixtures include gooseneck spouts which are mounted at the rear of the basins along with handles and showerheads. The line was designed for use in examination and treatment rooms, central service and for general laboratory service. **Crane Co., 836 S. Michigan Ave., Chicago 5.**

For more details circle #214 on mailing card.

WHAT'S NEW

Hypo Needle Cleaner Accommodates All Sizes

All sizes of hypodermic needles can be thoroughly and quickly cleaned in the new Tomac Hypo Needle Cleaner.

It cleans twelve needles at a time with no intricate mechanism and accommodates any sized needle. An electrically powered low r.p.m. motor drives the brush for scouring the needles. Alternating streams of detergent and water finish the cleaning.

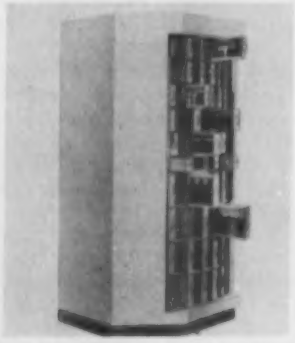
The Tomac Compressor supplies compressed air for the Needle Cleaner. A special inlet muffler filter assures clean intake air supply and furnishes clean, dry, oil-free air. All parts are permanently lubricated and the unit is quiet in operation. Smooth operation even on uneven surfaces is assured by the rubber cushions under the base. The unit is supplied with a carrying handle for ready portability. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #215 on mailing card.

Revolving Cabinet for Drug Storage

Designed especially for drug storage, the new Drug-Stower is a compactly built cabinet that can be revolved for easy access to all contents. It is so engineered as to offer 360 feet of shelving while occupying an area only four feet six inches square. There are 180 various sized compartments forming a circular, vertical tier which can be rotated. Each compartment contains a removable "stow" drawer and all drawers are numbered to facilitate indexing for quick location of any desired drug.

Large ball thrust bearings mounted on



steel angles assure free rotation in either direction. A built-in foot-operated brake in the base of the cabinet provides a convenient and smooth stopping device. Drawers are made of metal with wood ends in natural wood finish. Exposed parts of the cabinet are made of birch with white enamel finish. **G. A. Hasemann Mfg. Co., 2357 S. Seventh St., St. Louis 4, Mo.**

For more details circle #216 on mailing card.

Selective Paging by Pocket Radio

The Pagemaster is a selective radio paging system designed to locate personnel quickly without disturbance. About the size of a package of cigarettes, the Pagemaster radio decoder can be carried in the pocket of a nurse, doctor or other hospital personnel. Each decoder responds to a certain coded radio signal. When its signal is received, a pleasant audible tone is heard which is a message to the individual carrying or using the decoder that he is being paged. The page is answered at the nearest telephone. Personnel that may be relatively inaccessible can thus be quickly and quietly reached in any area of the hospital when carrying the Pagemaster and general audible signals are not necessary.

The Pagemaster weighs only seven

ounces and is 2½ by 3⅛ by one inch in size. The colorful, smooth plastic case contains the entire unit, with no external wires or other attachments. Power is supplied by a special compact power pack which can operate the decoder for several weeks. For smaller institutions the Pagemaster system provides up to 64 individual channels. For large installations a paging service with up to four thousand channels is available.

The encoder transmitter is a small cabinet or console, usually set up at the telephone switchboard, on the front of which are dials with which the coded signals are set up. Coded signals are qiuckly set into the transmitter which automatically sequences them and continues to transmit them until removed by flipping a switch. **Stromberg-Carlson, Telephone Div., Rochester 3, N. Y**

For more details circle #217 on mailing card.

Full Door Opening With Swing-Clear Hinges

Doors swing completely clear of their openings to facilitate moving beds and other furniture, stretchers and carts without interference with the new Swing-Clear hinges. The hinges are especially suited to use in patients' rooms, operating and emergency rooms and for unimpeded passage through any door frame.

Swing-Clear hinges are available in the full-jeweled, full-surface wide-throw hinge No. BB266 and the half mortise full-jeweled hinge No. BB264. They are made from extra heavy, cold-rolled wrought steel, highly polished and heavily plated in all standard finishes, or bonderized and prime coated for painting. Each hinge is equipped with four Stanley permanently lubricated full-jeweled ball bearings. **The Stanley Works, New Britain, Conn.**

For more details circle #218 on mailing card.

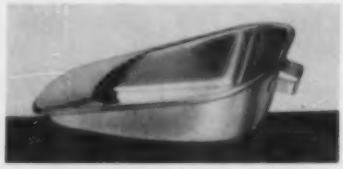
Grease Interceptor for Low-Outlet Appliances

The new Series JHL Low Boy Grease Interceptor was designed primarily for installation on dishwashing machines and other low outlet fixtures to eliminate trapping the interceptor inlet or holding water in the basin. Accumulated grease is drawn off into a convenient storage container by turning a valve. Grease flows out of the draw-off valve, eliminating removal of grease by hand. **Josam Mfg. Co., Michigan City, Ind.**

For more details circle #219 on mailing card.

Fracture Bed Pan of Stainless Steel

The new No. 8902 Fracture Bed Pan of stainless steel is a small, flat utensil designed for use with immobilized patients. The low, flat sloping top makes it easier to use with patients unable to move. The stainless steel pan is con-



structed to conform to rigid sanitary standards and is easy to clean. It is durable, convenient and practical. **The Vollrath Co., Sheboygan, Wis.**

For more details circle #220 on mailing card.

(Continued on page 190)

WHAT'S NEW

Overbed Table Has Telescoping Pedestal

Spring loaded, vacuum controlled construction of the telescoping pedestal prevents the new Colson overbed table from falling. It was designed by Miss L. E. DuBach of Kansas City who also designed the DuBach surgical instrument table. When the locking lever is released on the overbed table it rises slowly and smoothly without disturbing liquids or other articles. To lower, the table is pushed down and locked in place.

Cast aluminum is used for the construction of the T-shaped pedestal which will go under the bed or other object with a three inch floor clearance. The table has wood trim with a Formica top. It will hold 150 pounds of weight, is adjustable from 28 to 48 inches in height, and is sturdy and maneuverable. It has an adjustable center rack for reading in bed. **The Colson Corporation, Elyria, Ohio.**

For more details circle #221 on mailing card.

Electrodyne D-72 for External Defibrillation

Defibrillation through the unopened chest can be accomplished with the new Electrodyne D-72. Designed for clinical treatment of ventricular fibrillation and persistent tachycardia, the instrument can also be used for defibrillation of the exposed heart. The countershock or impulse duration is automatically fixed at .15 seconds. The countershock voltage

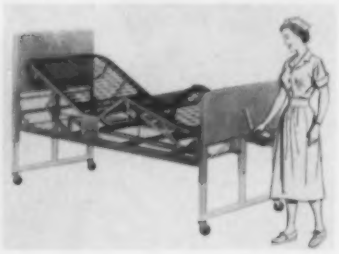
may be varied in steps up to 750 volts and is capable of delivering up to 15 amperes through the chest wall. The automatic timing circuit, which fixes the impulse duration at .15 seconds, does not allow successive countershocks more often than one per second. The patient is thus protected from undue heating. Other safety features are built into the D-72 to provide maximum protection for the operator and the patient. **Electrodyne Co., Inc., Endicott St., Norwood, Mass.**

For more details circle #222 on mailing card.

Single-Action Crank on Multiple Height Bed

A single crank is used to raise and lower the new No. 872 Inland Single-Action Multi-Height Hospital Bed. A new type permanent counter-balanced spring mechanism makes it as easy to raise the bed with the patient in it as to lower it. A minimum number of turns is necessary to raise the bed from home to hospital height in approximately twenty seconds. The bed is equipped with Inland's No. 8 All-Position Heavy Duty Gatch Spring which is available in 76 and 80 inch lengths.

The permanently attached single crank is located in the center of the foot panel of the bed and folds flat when not in use. It raises head and foot ends simultaneously. Separate cranking of the ends



for special needs is accomplished by a lever adjustment. **Inland Bed Co., 3921 S. Michigan Ave., Chicago 15.**

For more details circle #223 on mailing card.

Aluminum Draw Draperies in Vertical Blinds

The Flexalum Draw Drapery of bright-hued aluminum gives the effect of a vertical venetian blind. It can be fully closed to give window darkening, or set on any angle to become a venetian blind. Specially-designed traverse rods are covered by an attractive cornice. The draperies slide neatly across windows or doorways with a pull at a single, looped, soilproof cord. They can also be used as room dividers. The new blinds offer complete light control without obstructing ventilation. The vertical slats are easily cleaned and do not bend out of shape. They are offered in a variety of attractive colors, which are marproof and will not chip, crack or peel. **Hunter Douglas Corporation, 150 Broadway, New York 7, N. Y.**

For more details circle #224 on mailing card.

(Continued on page 192)

weeks?

months?

years?

Improve the prognosis in fractures with "Premarin" with Methyltestosterone

Healing of fractures is often delayed because impairment of osteoblastic activity due to declining sex hormone function causes the bone matrix to atrophy.

Older patients with fractures, particularly of the hip, respond well to combined estrogen-androgen therapy. The prognosis for bone recalcification is good provided treatment is continued for extended periods.*

*Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, ed. 2, New York, The Blakiston Company, Inc., 1954, chap. 98, pp. 702, 703.

"PREMARIN"® with METHYLTESTOSTERONE

Excellent preparation for estrogen-androgen therapy

Ayerst Laboratories • New York, N. Y. • Montreal, Canada

Ayerst

5647

Plastic Tumbler and Dish Styles Expand Cloverlane Line

The newest additions to Cloverlane melamine dinnerware meet a variety of needs. The new Starlane Tumbler, made

of break-resistant plastic, is shatterproof and lightweight, stacks without sticking and has a long service life. The Starlane comes in a five ounce fruit juice tumbler, a 9½ ounce water tumbler and a 12 ounce ice tea tumbler.

The added styles and sizes rounding out the dinnerware line include a nine inch oval platter, an 11½ inch oval platter, an eight inch luncheon plate, a 10 inch dinner plate and a 14 ounce soupe coupe. **Chicago Molded Products Corp., Dinnerware Div., 1020 N. Kolmar Ave., Chicago 51.**

For more details circle #225 on mailing card.

Laparatomy Pad in Davol Rubber

Assistance in obtaining a clear operative area is claimed for the new Davol improved rubber Pelvic Laparatomy Pad. It is especially designed to exclude the bowel and omentum from the operative field, thus reducing also the possibility of bowel trauma. The new pad is easy to insert and to clean and can be sterilized for repeated use. **Davol Rubber Co., 69 Point St., Providence 2, R.I.**

For more details circle #226 on mailing card.

Medicspray Spray Dressing Is Transparent and Flexible

A new first-aid dressing is offered in Medicspray Bandage. The clinically-tested product is transparent, flexible, durable and washable. It is sprayed on cuts, excoriations, abrasions and wounds of many types, both operative and traumatic, forming a biologically and chemically inert film that is insoluble in body fluids. It keeps out dust, dirt and other contaminants and permits critical evaluation of healing progress at all times without removal and re-dressing. Circulation, respiration or any desirable movement is not restricted with the flexible dressing which does not rub off but which may be easily removed when necessary. It may be applied over sutures and withstands washings. **General Cosmetics Corp., 612 N. Michigan Ave., Chicago 11.**

For more details circle #227 on mailing card.

Portion Control Pack for Soft Drink Crystals

New portion control foil packages are now available for Lem-O-Rich soft drink crystals. The 2¾ ounce package dissolved into two gallons of water with sugar is designed to make a refreshing lemon drink. A lemon juice strength liquid for cooking and baking is made by dissolving the contents of one portion control package in a quart of water. Each package has the flavoring capacity of 35 fresh lemons, according to the manufacturer. **Edward Don & Co., 2201 S. La Salle St., Chicago 16.**

For more details circle #228 on mailing card.

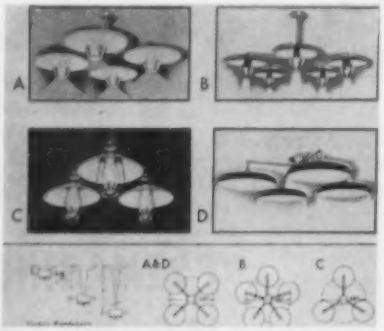
X-Ray Screens Are Aluminized

An aluminum back-coat which inhibits moisture absorption and wrinkling, provides greater dimensional stability and longer life is incorporated into the new Radelin aluminized x-ray screens. The coating also absorbs high potentials, minimizing static discharges. Film-screen contact is improved through use of a new card stock and a new, whiter reflective coating reduces light loss. A thinner phosphor layer is used to improve detail and a protective coating is added for resistance to abrasion and chemical stains. The new features are included on all four types of Radelin intensifying screens with no changes in speed. **U. S. Radium Corp., 535 Pearl St., New York 7.**

For more details circle #229 on mailing card.

Decorative Fixtures for Lighting Public Areas

An easily installed, attractive decorative lighting fixture for hospitals and other institutions in public areas is now available in the Virden Wondabar. The inexpensive hub and spoke framework



support either three, four or five lighting fixtures, according to need and personal taste. Length of spokes and depth of the ceiling attachment can be varied according to conditions and designs selected. A variety of types of fixtures are available for use with the Wondabar, some of which are illustrated. **John C. Virden Co., 6103 Longfellow Ave., Cleveland 3, Ohio.**

For more details circle #230 on mailing card.

WHAT'S NEW

Disposable Pads for Nursing Mothers

Johnson's new nursing pads are contour shaped and fully disposable. They

are made of highly absorbent cotton with repellent cellulose backing which is completely covered with a soft non-woven fabric. The pads are anatomically shaped to fit the breast with full coverage of the nipple, areola and adjacent area for full protection of clothes and bedding. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #231 on mailing card.

Refrigerated Milk Dispenser Is Self-Leveling

Automatic dispensing of milk containers at convenient counter level is provided with the new Lowerator Mobile Refrigerated Milk Dispenser. It can be easily wheeled into counter openings or adjacent to serving lines and accommodates milk cartons or bottles of any size or shape. The all-swivel casters and the handle facilitate positioning.

The mobile, compact, self-contained unit features sanitary, refrigerated interim storage. The calibrated spring mechanism keeps the top rack always at the same convenient level, whether the unit is full, half-filled or nearly empty. The dispenser is of all stainless steel construction with the dispensing unit, compressor, evaporator and thermostat completely enclosed. The new unit has Underwriters Laboratories approval, according to the manufacturer. **American Machine & Foundry Co., Lowerator Div., 261 Madison Ave., New York 16.**

For more details circle #232 on mailing card.

Dial-A-Matic Photocopier Is Fully Automatic

A continuous automatic printer and continuous automatic processor are incorporated into one compact unit in the new completely automatic Dial-A-Matic Auto-Stat photocopy machine. The one-unit machine is designed to copy any material up to 15 inches wide, any length, simply and quickly. The color control dial is set for the type of copying to be done and anyone can make an accurate copy of any material that will go through the machine in a moment's time.

(Continued on page 194)

The color band section of the dial on the new machine includes white, yellow, green, blue and red. This is designed to coordinate the amount of light that is given to the original that passes through the printing section. Copies can thus be made from originals of any color with the dial automatically setting the exposure time required. The machine is housed in a durable, stainless steel case and the company states that the Apeco Dial-A-Matic Auto-Stat carries a full, lifetime guarantee. The machine pictured in use illustrates a motion study indicating the limited number of motions required to copy accurately even

the most compact and technical sheet of information or data. **American Photocopy Equipment Co., 1920 W. Peterson Ave., Chicago 26.**

For more details circle #233 on mailing card.

WHAT'S NEW

Catheter Introducer for Bronchography

Developed by Dr. Cesare Gianturco of Urbana, Illinois, the Gianturco Catheter Introducer is an instrument for introducing a tracheal catheter under visual control. It is designed for single handed operation of the introducer and the catheter, and is easily and quickly withdrawn, allowing the catheter to remain in place for bronchography.

The instrument incorporates an electric seed lamp, a laryngeal mirror, a tongue depressor and a channel for the catheter. Batteries are contained within the handle. It is designed to facilitate tracheal catheterization. **Picker X-Ray Corp., 25 S. Broadway, White Plains, N.Y.**

For more details circle #234 on mailing card.

Soap Dispenser Has Streamlined Design

The new Septisol Soap Dispenser offers a new streamlined design for better appearance and easier cleaning. The newly designed pneumatic foot pump which dispenses soap with slight pressure of the toe, is so designed that it can cause no static electricity as all parts are grounded by a specially formulated rubber which also assures long, trouble-free operation.

The air intake and hose nipple are recessed and concealed and there is no complicated mechanism to get out of order. The control valve accurately regulates soap flow to prevent waste and the scientifically designed dispensing spout eliminates drip. The spout can be swung from left to right as required and is easily removed. **Vestal Incorporated, 4963 Manchester Ave., St. Louis 10, Mo.**

For more details circle #235 on mailing card.

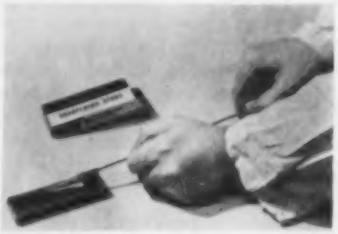
Additional Patterns in Guard Wall Coverings

Three new designs have been added to the Guard line of coated fabrics for walls. The Guard line is scuff-proof, stainproof, washable and fire resistant on or off the wall. Added to the Sentinel line now on the market are the new Guard designs of Staccato, in ice blue, turquoise, willow green, mocha, flame and mist green; Bayou in off-white, gray and mocha; and Venetian Brick in light yellow, aqua, mocha, gray, mustard and mist green. **Columbus Coated Fabrics Corp., 1280 N. Grant Ave., Columbus 16, Ohio.**

For more details circle #236 on mailing card.

Grooved Sharpening Stone for Surgical Instruments

Four grooves, one, two, four and eight mm in diameter, are set in the new grooved sharpening stone developed by Behr-Manning. Instruments with rounded tips are readily sharpened and backs of scrapers and curettes are kept rounded and smooth with the new hone. It is



made of hard Arkansas stone, a pure novaculite which is used to provide a high quality cutting edge when honing with either oil or water. **Behr-Manning Div., Norton Company, Troy, N.Y.**

For more details circle #237 on mailing card.

WHAT'S NEW

Commercial Vacuum Cleaner for Dry Pick-Up

A capacity of two-thirds bushel of dirt makes the new Viking vacuum

cleaner effective as a furnace cleaner as well as for all institutional dry pick-up work. It is priced for low cost application and powered by a ¾ h.p. AC/DC motor. The Viking weighs only forty pounds. Mounted on four three inch ball bearing casters, it is moved without excess effort. The compact size makes the Viking easily stored and it is adapted to all vacuum operations through the use of the large selection of tools available. **Kent Company, 736 Canal St., Rome, N.Y.**

For more details circle #238 on mailing card.

Cool Comfort for Patient Gowns

A lightweight, cool patient's gown of plissé is now available for summer wear. It is offered in Mist Green or white in a practical, comfortable style. Short, extra wide sleeves make the gown comfortable and the lower cut neck with heavy tape reenforcement and double yoke are added features. The gown is reasonable in price, easy to launder, requires no ironing and comfortable for the patient. All tapes are bartacked for permanence. **Kuttnauer Mfg. Co., 2189 Beaufait Ave., Detroit 7, Mich.**

For more details circle #239 on mailing card.

Grounding Receptacle for Two Separate Circuits

A new three wire, two wire Combination Duplex Grounding Receptacle is now available which provides for two separate circuits with a common ground. The new receptacle provides current, from the same outlet, to operate an appliance which requires three wire, 15 ampere, 250 volt service and any other appliance requiring only two wire, 15 ampere, 125 volt service. Special slots eliminate the possibility of errors in plugging appliances into the power. **The Arrow-Hart & Hegeman Electric Co., 103 Hawthorn St., Hartford 6, Conn.**

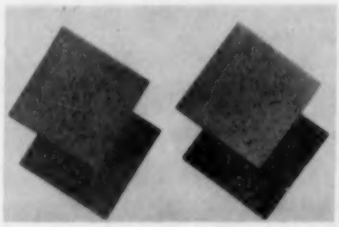
For more details circle #240 on mailing card.

(Continued on page 196)

Four New Colors in Resilient Floor Tile

Two colors have been added to each of the resilient floor tile lines offered by Azrock Products. Azphlex vinylized tile offers PK-751 Lisbon Cork and PK-752 Dakar Cork to its line of 3/32 inch Cork Terrazzo Tone patterns. The new colors are similar in appearance to natural cork and are available in nine inch square tiles.

Azrock asphalt tile is offered in two new terrazzo tone patterns. Dazzle, color B-523, is a reddish brown background with multi-colored chips. A white background with gray and black chips is introduced as Polkadot, D-561. These colors are available in the nine inch



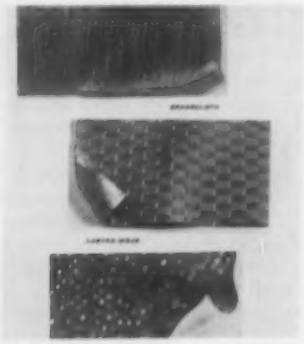
square tiles in ⅛ inch thickness. **Uvalde Rock Asphalt Co., Azrock Products Div., 510 Frost Bank Bldg., San Antonio 6, Texas.**

For more details circle #241 on mailing card.

WHAT'S NEW

Three Attractive Patterns in Vicrtex Vinyl Fabrics

Vicrtex vinyl electronically fused fabrics for wall coverings, furniture upholstery



and other areas where attractive but sturdy materials are required are now available in three new patterns. All materials are completely washable, resistant to stain or soil, flame retardant and constructed so that they do not chip, crack or peel.

Grass Cloth is a rough-textured finish with the sheen and textural depth of grass cloth. It is designed for use with either modern or traditional decor. Lustra-weve gives the illusion of satin threads outlining alternating rectangles of a duller surface weave. The third new pattern is known as Mira-Disc, with many faceted dots that give the illusion of changing shades of color and shimmer. **L. E. Carpenter & Co., Inc., Empire State Bldg., New York 1.**

For more details circle #242 on mailing card.

Acoustical Ceiling Panel Is Non-Combustible

A new version of Tectum is now available as an acoustical ceiling panel. The non-combustible material provides low cost sound control. The square edged wood fiber panels are 24 by 48 inches in size. In addition to their high acoustical properties, the panels also serve as insulation. The factory applied felt backing provides a barrier against sound transmission.

The panels may be installed by mechanical suspension or may be nailed to furring strips. The new material combines light weight with structural strength and rigidity, requiring only everyday woodworking tools for cutting. It has an attractive off white color which can be painted without affecting acoustical properties. **Tectum Division, Peoples Research & Mfg. Co., Newark, Ohio.**

For more details circle #243 on mailing card.

Medical Scanner for Radioisotope Distribution

Designed to chart radioactive iodine distribution in the thyroid gland, the new Model 1700 Isotope Scanner may be used for delineating any other organ in the body in which a radioactive isotope is localized. It can be used in diagnosing a pathological condition, planning for surgery, or determing organ bulk in planning therapeutic dosage. The scanner is used with a scaler and collimated directional scintillation detector to scan the body areas for concentrations of radioactivity, while simultaneously picturing the radioisotope distribution.

The instrument may be set to scan a body area as large as 14 by 17 inches. The printing mechanism is a solenoid suspended over carbon-backed paper. A line is produced on the paper for each preset number of detected radioactive

disintegrations. The operator can see the entire printing surface during the whole scanning. **Nuclear Instrument & Chemical Corp., 229 W. Erie St., Chicago 10.**

For more details circle #244 on mailing card.

WHAT'S NEW

Tray Covers and Napkins Feature Animals

Pediatric patients will enjoy the new "Younger Set" tray cover and napkin

combinations featuring animals and the alphabet. The children's ensemble shows humorous drawings of animals, each playing with the letter with which its name begins. They are thus educational and entertaining as well as attractive in the two-color designs. Napkins have a four-color effect with special designs. **Aatell & Jones, Inc., 3360 Frankford Ave., Philadelphia 34, Pa.**

For more details circle #245 on mailing card.

Dishwashing Compounds Meet Specific Requirements

Specific dishwashing needs can be met exactly with the seven new Solventol cleaning preparations recently introduced. Based around the basic solvent principle, the new products combine modern synthetic solvents and synthetic distillates, each pointed toward a specific problem by the addition of other special elements.

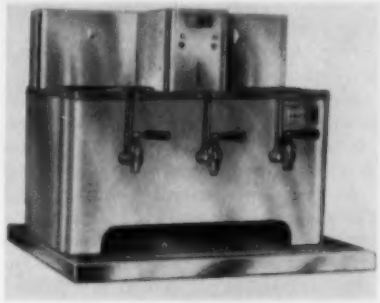
The seven special Solventol dishwashing compounds include No. 101, Solventol Hand Dish Wash, built for high efficiency at the low temperatures of hand dishwashing; No. 201 Solventol Machine Dish Wash, which "breaks" organic fats and albumin at once and rinses perfectly; No. 303 Solventol Machine Dish Wash for heavy duty washing; No. 203 with aluminum inhibitor for safe, quick washing of aluminum; No. 301 for removal of heavy grease on pots and pans, with glycerine added to protect hands; No. 401 Solventol Silver Drying Agent which eliminates towelling of silverware, and No. 501 Solventol Dish Drying Agent which eliminates towelling of dishes and glassware. **Solventol Chemical Products, 15843 Second Blvd., Detroit 3, Mich.**

For more details circle #246 on mailing card.

Push-Button Coffee Maker Reduces Costs

A completely new and automatic line of push-button coffee makers is now available. The Best Coffee Maker is constructed to brew flavorful coffee under the most scientific methods and controls and yet at minimum cost. Savings in cost are effected by efficient operation and the control possible with electronic devices, as well as in labor.

Twelve models are offered in the new line, including gas and electric heated units with single and double dispensing facilities. A conveyor set-up is also available which permits serving coffee with or without cream from one single station. Brewing capacities of the new models vary from one to twenty gallons. Coffee is brewed by the drip method. Units may be manually operated if desired. Improved features of the new



line of Best Coffee Makers are described in a brochure available from the manufacturer. **Best Products Co., 2600 W. Addison St., Chicago 18.**

For more details circle #247 on mailing card.

(Continued on page 198)

WHAT'S NEW

Ziradryl Lotion

Ziradryl Lotion, containing zirconium oxide, benadryl hydrochloride and camphor, is introduced for the prevention and treatment of poison ivy and poison oak. The chemicals in the lotion neutralize action of poison oak or ivy, reducing inflammation and relieving itching. Application of Ziradryl Lotion, or Ziradryl Cream previously introduced, when contact with poison oak or ivy is anticipated, is recommended as a preventive of allergic reactions. **Parke, Davis & Co., Detroit 32, Mich.**

For more details circle #248 on mailing card.

Combiotic

Combiotic is a two-in-one administration combining specific dual action with increased safety. It has the specific primary activity of penicillin on gram-positive bacteria and streptomycin on gram-negative bacteria, plus overlapping cross-spectrum activity for increased overall effectiveness. It is available in a new Steraject single-dose disposable cartridge with sterile needle attached in aqueous suspension, and in dry powder form in two formulas, 1.0 and 5.0 gram. **Pfizer Laboratories Div., Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #249 on mailing card.

Ritalin Hydrochloride

Ritalin hydrochloride is a mild psychomotor stimulant indicated in the treatment of depression and chronic fatigue, drug-induced oversedation and lassitude, disturbed senile behavior and narcolepsy. It gently raises patients to normal levels of mental and physical performance without producing hyperexcitability or depressive rebound. Ritalin is supplied in 5 mg. 10 mg. and 20 mg. tablets in bottles of 100, 500 and 1000. **Ciba Pharmaceutical Products Inc., Summit, N.J.**

For more details circle #250 on mailing card.

Thoradex

Thoradex is a new combination drug providing a balance of Thorazine and Dexedrine. It is indicated for treatment in a wide variety of mental and emotional disturbances marked by anxiety, agitation, apprehension and depression, in somatic conditions in which emotional stress is a complicating or a causative factor, and when Thorazine alone causes undesirable drowsiness. Thoradex is available in tablet form, in two strengths, in bottles of 50 and 500. **Smith, Kline & French Laboratories, 1503 Spring Garden St., Philadelphia 1, Pa.**

For more details circle #251 on mailing card.

Colace

Colace incorporates a new principle in the treatment of constipation. It is a non-laxative stool softener designed to aid the sufferer from chronic constipation to achieve normal elimination without the discomfort of irritant-action medication. The new product is a wetting agent which aids elimination by preventing dehydration of waste material in the colon. By passive action, it helps the waste matter to absorb moisture in the intestine, thus facilitating the natural eliminative process. It has no stimulating action on the intestinal muscles. Colace is supplied in 50 mg. capsules in bottles of 30 and 500. It is also available in one per cent solution in 30 cc and 16 ounce bottles. **Mead Johnson & Co., Evansville 21, Ind.**

For more details circle #252 on mailing card.

Sparine

Sparine is a new potent ataractic drug indicated in the management of acutely agitated patients. Sparine therapy may be initiated by intravenous injection when required, followed by intramuscular or oral administration. It is rapidly effective and patients become quiet, calm and tractable. It is safe and dependable when administered in accordance with directions. Sparine is supplied in 50 mg. per cc vials and in tablets of 25, 50, 100, 200 mg. **Wyeth Laboratories, 1401 Walnut St., Philadelphia 2, Pa.**

For more details circle #253 on mailing card.

Product Literature

• The special ceramic tile developed especially for use in hospitals for floors in operating rooms and adjoining areas, and in all other rooms where anesthetics are used or stored, is discussed in a new folder available from American-Olean Tile Co., 1000 Cannon Ave., Lansdale, Pa. **Folder No. 506** tells how Conduct-O-Tile floors dissipate static electricity and eliminate the principal cause of anesthetic explosions.

For more details circle #254 on mailing card.

• The use of an inside telephone system to coordinate hospital administration is discussed in **Business Telephone Report No. 107** issued by Automatic Electric Co., 1033 W. Van Buren St., Chicago 7. Subject of the folder is St. Francis Hospital in Lynwood, California and its use of the P-A-X telephone system in performing vital functions, saving valuable time and improving efficiency of operation of the hospital.

For more details circle #255 on mailing card.

• **Dura-Decor coated Fiberglas drapery and curtain fabrics** are the subject of a new catalog released by Duracote Corporation, Ravenna, Ohio. The file folder form catalog contains descriptions of Dura-Decor fabrics, suggested uses for different installations, illustrations of usage and samples of weights, patterns and colors.

For more details circle #256 on mailing card.

• Based on the concept that everyone does not know how to sweep, the National Sanitary Supply Association, 139 N. Clark St., Chicago 2, has issued **Bulletin Board No. 6, Sweeping Stairs.** The 17 by 22 inch illustrated poster describes the proper work methods for sweeping stairways and serves as a valuable training aid for maintenance employees.

For more details circle #257 on mailing card.

• **"Mills Movable Metal Walls provide Space Control"** titles the 1956 68-page catalog issued by Mills Co., 968 Wayside Rd., Cleveland 10, Ohio. Including complete information on design and construction features with specifications and detail drawings, the illustrated catalog shows the advantages of flexible interiors for institutions and other buildings. The entire line of Mills accessories and hardware is also described.

For more details circle #258 on mailing card.

• An illustrated brochure describes the advantages and uses of the new **Chip-Freeze automatic ice-maker.** Available from the Cold Corporation of America, 1371-89 N. North Branch St., Chicago 22, the booklet contains distinguishing features and mechanical specifications of the Chip-Freeze equipment which is available in six colors.

For more details circle #259 on mailing card.

(Continued on page 200)

Stevens Utica Sheets are famous for extra-long wear! Through years of use they keep their lustrous surface, their soft, smooth touch . . . thanks to the exclusive Delta Finish. Choosing Utica Sheets assures long range economy for you; extra comfort for your patients.

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STEVENS SIMTEX NAPERY gives trays and tables the fresh, inviting appearance so important for patients. Despite constant laundering, Simtex keeps its fine, crisp hand, its gleaming surface. The exclusive Basco protective process is applied *permanently* to the fiber itself, and gives Simtex *unsurpassed durability,* by actual test.

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July, 1956

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

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Key

ex to Products Advertised—*Continued*

WHAT'S NEW

• Stainless steel food conveyors for decentralized and centralized food distribution systems are the subject of **Catalog T-5** issued by S. Blickman, Inc., Weehawken, N.J. The 32 page booklet, fully illustrated, is a guide to purchasing as it contains complete specifications and detailed descriptions of food conveyors and various construction features of each. The complete line of food conveyors manufactured by the company includes electrically-heated all-purpose bulk food conveyors in a wide variety of arrangements, new types of central service conveyors for hot and cold foods, bulk food trucks for cafeteria service and tray and dish trucks.

For more details circle #260 on mailing card.

• A new 150 page catalog of **Rehabilitation Products** is offered by the Rehabilitation Products Division, American Hospital Supply Corp., Evanston, Ill. The catalog covers rehabilitation and physical therapy equipment for every need and is the result of years of testing and screening equipment and supplies. Over 750 products are illustrated and described and a complete index makes quick reference possible. Included in the catalog is information on equipment for electro, hydro and heat therapy; diagnostic, exercise, respiratory and self-help items; furniture; mobile units; orthopedic equipment; sundries, and miscellaneous general hospital items.

For more details circle #261 on mailing card.

• How to determine the proper control system for direct radiation is discussed in non-technical language in **Bulletin CA-12** issued by Barber-Colman Company, Dept. 766, Rockford, Ill. Illustrated with charts and graphs, the bulletin includes control of steam and hot water and discusses both two-position and proportioning modes of control.

For more details circle #262 on mailing card.

• How the hospital can **"Save Money on Pro-Tex-Mor Hospital Products"** is discussed in a new catalog offered by Central States Paper & Bag Co., 5221 Natural Bridge, St. Louis 15, Mo. New additions to the line which are described in the catalog include waterproof waste can liners and catheter sterilizer bags and guides.

For more details circle #263 on mailing card.

• Recommendations for using Amphyl brand disinfectant are discussed in two helpful instruction folders released by Lehn and Fink Products Corp., Professional Div., 445 Park Ave., New York 22. **"How to Use Amphyl in the Operating Room"** and **"How to Use Amphyl for Instrument Disinfection"** cover the subjects with instructions and suggestions for procedures. The two new cards, as well as the earlier ones for use in Tuberculosis Hygiene and General Disinfection, are available in quantities for personnel training.

For more details circle #264 on mailing card.

• Thirty-one items have been added to the Angelica line of hospital garments. The new **Hospital Catalog Supplement** illustrates and describes additions to the line and a **Style Guide** lists those styles which are offered as replacements for discontinued designs and mentions the improvements or changes which are incorporated into the new garments. Copies of the Catalog Supplement and Style Guide are available from the Angelica Uniform Co., 1427 Olive St., St. Louis 3, Mo., or from any of that company's regional offices.

For more details circle #265 on mailing card.

• An attractively laid out and printed 24 page booklet on **"The Modern Hospital and Its Elevator Needs"** is now available from Otis Elevator Co., 260 Eleventh Ave., New York 1. It outlines the special problems and requirements of passenger and freight elevatoring and dumbwaiter service in hospitals, and describes the latest developments in vertical transportation to meet them. How vertical traffic requirements vary according to the type and size of the hospital are discussed as is the subject of automatic elevators and their adaptation to the special requirements of hospitals.

For more details circle #266 on mailing card.

• **"Grand Rapids Sectional Equipment for the Hospital Pharmacy"** is discussed in an eight page folder recently released. How the sectional pharmacy equipment, "basic as building blocks," can be used to develop the ideal pharmacy for each individual need is discussed and suggested blue prints of pharmacy layouts are included in the pamphlet issued by Grand Rapids Sectional Equipment Co., 200 Fuller Bldg., Grand Rapids 6, Mich.

For more details circle #267 on mailing card.

• **Specialized bulletin board service** to aid the hospital in personnel, patient and public relations programs is discussed in a six page folder issued by Hospital Personnel Div., Marlin Industrial Division, 79 Willow St., New Haven, Conn. The folder pictures examples of the visual, educational program material designed to help prevent hospital accidents, stop waste, cut costs and improve personnel and public relations. A partial list of hospital subscribers and copies of testimonial letters are included.

For more details circle #268 on mailing card.

• **Specialized Laundry Equipment** manufactured by Eastern Cyclone Conveyor, 876 Van Houten Ave., Clifton, N.J., is discussed in a 12-page catalog recently released. The reference manual illustrates and describes the Lint Collector, Circulating Soap System and Wash Machine Loading Hopper developed by the company. Included are data on operation, installation and assembly as well as weights, sizes and capacities of the various types and models.

For more details circle #269 on mailing card.

• **"Stainless Steel Surgeons Needles"** are the subject of a catalog issued by The Torrington Co., Torrington, Conn. The full line of surgeons needles are described and illustrated in exact size. A surgeons needle conversion chart is also included.

For more details circle #270 on mailing card.

• **Bulletin 100** issued by Despatch Oven Co., 819 Eighth St., S.E., Minneapolis 14, Minn. covers the four redesigned models of laboratory and production ovens. The color-illustrated brochure features the new engineering, construction and control features of the "V" series ovens with information on oven types, applications, capacities and specifications for gas and electric fired ovens.

For more details circle #271 on mailing card.

• **"The Care and Sterilization of Surgeons' Gloves"** is presented in a new manual available from Wilson Rubber Co., 1220 Garfield Ave. S. W., Canton 6, Ohio. Proper glove care is described in 11 steps which are said to facilitate asepsis, reduce wear and tear of gloves and save time.

For more details circle #272 on mailing card.

Book Announcements

Huffman, "Manual for Medical Record Librarians," 4th ed., 636 pp., $9.75. **Physicians' Record Co., 161 W. Harrison St., Chicago 5.**

For more details circle #273 on mailing card.

Frobisher, Sommermeyer and Goodale, "Microbiology and Pathology for Nurses," 4th ed., 845 pp., $6.50. Goodale, "Nursing Pathology," 2nd ed., 384 pp., $4.50. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #274 on mailing card.

"A Stereoscopic Atlas of Human Anatomy," in three dimension Kodachrome transparencies, text and dissections, David L. Bassett, M.D., photography, William B. Gruber, in three sections; Central Nervous System at $27.50; Head and Neck at $38.50; and Upper Extremity at $22.50. Four additional sections are still in preparation. **The Williams & Wilkins Co., Mt. Royal and Guilford Aves., Baltimore 2, Md.**

For more details circle #275 on mailing card.

Supplier's News

Fenestra Incorporated is the new corporate name of the **Detroit Steel Products Co., 2250 E. Grand Blvd., Detroit 11, Mich.**, manufacturer of steel windows which have carried the name Fenestra, the Latin word for window, since the company acquired exclusive patent rights from an English firm to manufacture and market the Fenestra window in the United States. The Fenestra label is now carried not only on the windows but also on wall, floor and ceiling panels, exterior and interior metal doors and roof deck.

YOU'VE GOT A PROBLEM IN SELECTION OF PATIENT GOWNS!

Appearances are deceiving. Unless you know the important differences in Patient Gowns, it is possible to make serious buying errors. "Plus" features may not always be obvious, but they are important to the durability and comfort qualities of the garment. It sounds difficult, and it really is!

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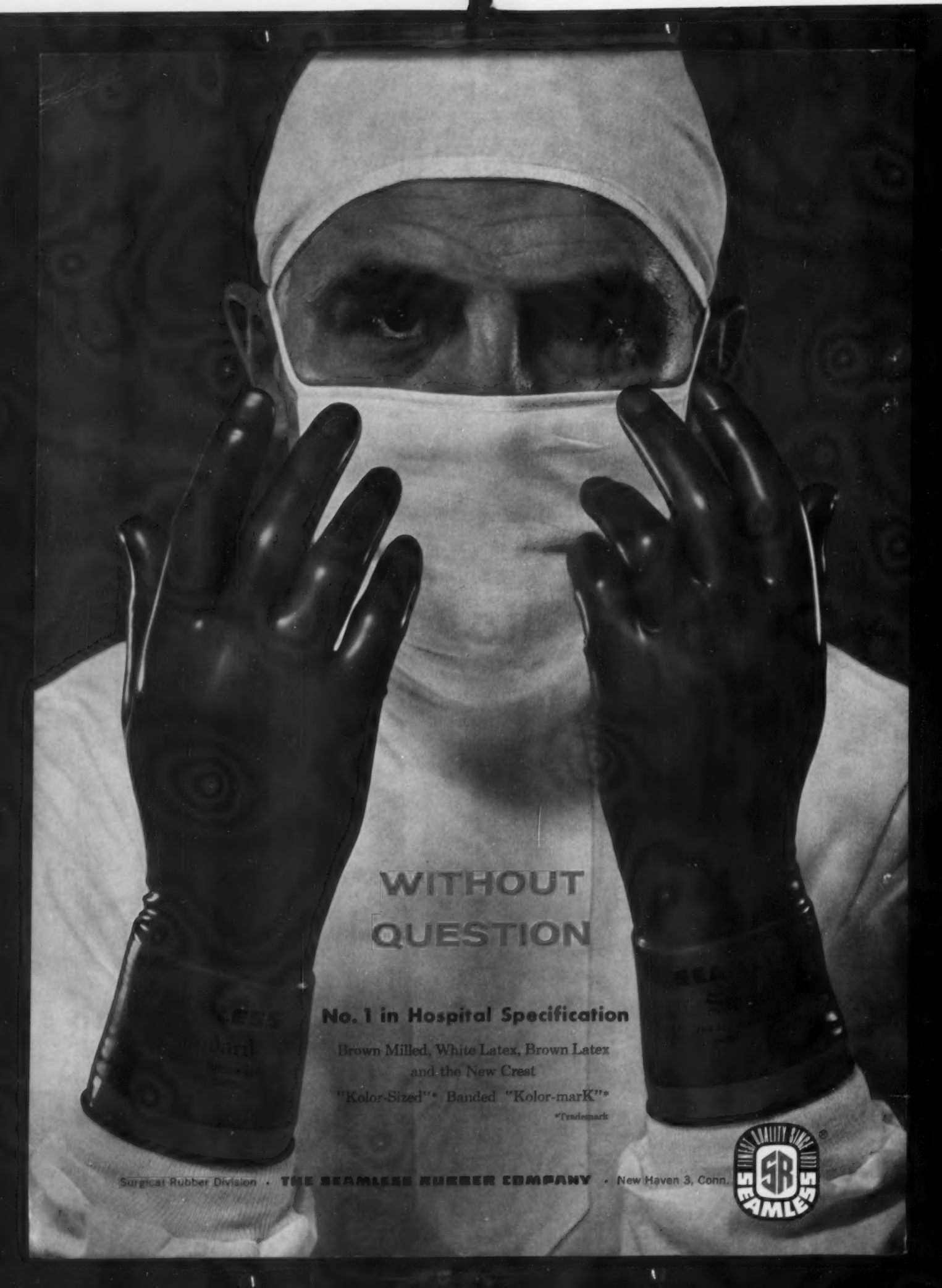
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